

# Rush Record

Fall/Winter 1997

A Publication of Rush-Presbyterian-St. Luke's Medical Center

## Dying with Comfort and Dignity



**Patients, families and caregivers begin  
a dialogue on improving care at the end of life.**



## **RushRecord**

Fall/Winter 1997

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More Americans are asking how we can better ensure that patients' needs are met at the end of life.



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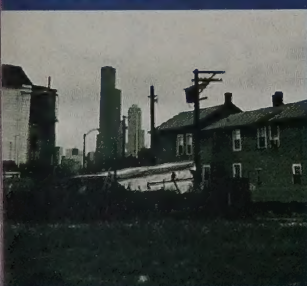
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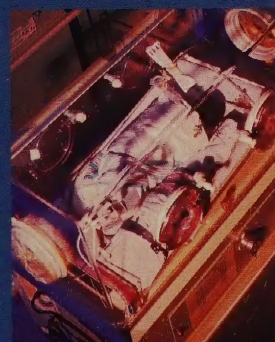
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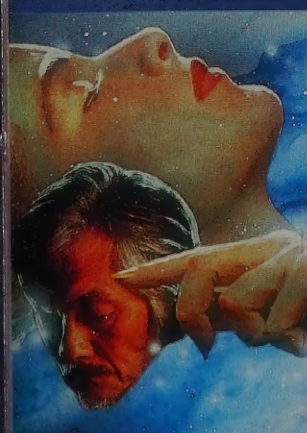
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"It's hard  
for physicians  
who are trained  
to treat and cure  
to admit that  
they can't do  
anything more  
for a patient."

Kathie Nash, RN



# Dying with Comfort

"Most of us live with three fears about death," says Kathie Nash, RN, executive director of Rush Hospice Partners, "dying in pain, dying alone and being a burden to those we love." Fortunately, medicine has advanced so rapidly in the last 60 years that these fears can be quickly abated in most cases, she says.

The use of morphine and other treatments has been refined so that most of the pain that accompanies cancer and other diseases can be relieved. Patients and families can also turn to hospices for help with the more personal aspects of death, including home nursing care and spiritual counseling.

But, shockingly, many people in the United States do not receive these services at the end of life, or receive them too late. About half die in severe pain, according to a recent study, and it is suspected that many others die alone, or without the chance to reflect on what their lives meant, says Nash.

What began, with the Karen Quinlan case, as a moral questioning of how technology is redefining death, has erupted into a national outpouring of concern. Confronted each day with news of physician-assisted suicides, the AIDS epidemic, and the public deaths of such revered figures as Cardinal Joseph Bernardin, more Americans are asking how we can better ensure that people die in comfort and with dignity.

The Rush community has also been deeply affected by the death of Roger C. Bone, MD, former dean of Rush Medical College, who challenged his colleagues to face the healthcare system's shortcomings in caring for dying patients (see his obituary, on page 28).

"We are so involved with the scientific that we may unconsciously ignore the dying part of living," Bone wrote in the *Journal of the American Medical Association*.

One of Bone's last goals was to establish a center at Rush that would focus on end-of-





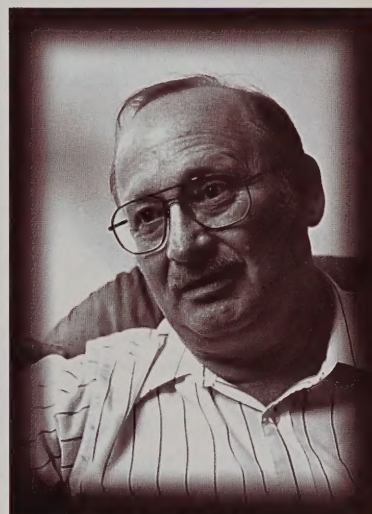
life concerns — the Institute for the Education and Study of the Dying Patient. This center co-sponsored the Medical Center's second annual conference on end-of-life issues last May. At this conference, physicians, nurses, lawyers and others debated a variety of topics, from proper pain management to dealing with grief. Many shared personal stories of patients or loved ones who had died — some with integrity, others in anger or extreme discomfort.

Northlake resident Larry Rogers believes that his wife, Sharon, had what she would have considered a good death. A nurse with Rush Hospice Partners, Sharon had helped hundreds of patients through their last months.

Two years ago, Sharon learned that the melanoma she thought she had beaten a decade before had returned. During the next 14 months, she underwent surgery twice to have tumors in her groin removed. But last Christmas, three more tumors were discovered. After talking with her doctor about other options, such as chemotherapy and radiation, Sharon accepted that these treatments would not greatly prolong her life.

**"When I needed an ear, there was always someone there."**

Larry Rogers



■ by Maggie Kennedy

# and Dignity



**"Death is a process of coping, of saying good-bye. For most, this takes several weeks or months."**

Steven K. Rothschild, MD

Over the last few months of Sharon's life, she and her husband relied greatly on Rush Hospice Partners, an organization that provides for the physical, emotional and spiritual needs of patients and families at the end of life. Staff arranged for a hospital bed to be delivered to the Rogers' home, and ensured that Sharon was as comfortable as possible. When Sharon's pain became extreme, she was moved to Oak Park Hospital, where hospice staff continued to provide comfort and emotional support around the clock.

"When I needed an ear, there was always someone there," says Larry.

The nurses also helped prepare Larry for what would happen to his wife during her last days. "They would tell me what was going on with her symptoms, or why she was reacting the way she was," he says. "This way when it did happen, I wasn't so shocked."

Many other survivors tell stories different from Larry's and Sharon's. A recent study found that many patients' wishes are disregarded at the end of life. Many received CPR or artificial respiration to keep them alive — even when they had signed advance directives requesting not to be resuscitated.

These findings document what many healthcare professionals already know: Asking patients to sign living wills and other advance directives is an important step, but it does not address the more complicated issues surrounding end-of-life care. Many point to the death-denying culture that exists in America, and a healthcare system that has worked so many miracles that clinicians and patients alike are dismayed when the options run out.

"It's hard for physicians who are trained to treat and cure to admit they can't do anything more for a patient," says Nash. "It's hard for patients too, especially those who come to a place like Rush looking for the latest and greatest. They expect that they are going to get well."

Many patients are referred to hospice too late to reap much benefit — about 40 percent die within two weeks of being referred. "Death is a process





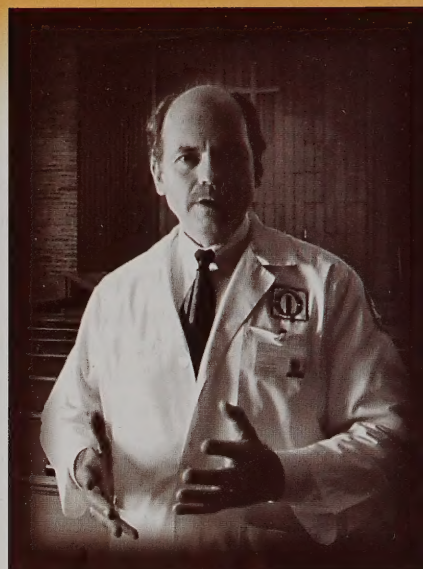
of coping, of saying good-bye. For most, this takes several weeks or months," says Steven K. Rothschild, MD, associate chairman, Department of Family Medicine, and past medical director for Rush Hospice Partners.

To give patients the full advantage of hospice care, Rush Hospice Partners encourages physicians to refer patients when they still have two to six months left to live. To help predict this, hospice staff have developed disease-specific guidelines that list the symptoms that appear when a patient is nearing death.

Hospice staff are also helping physicians talk to patients about their options once aggressive treatments have been exhausted. "These are not discussions you can have in one or two minutes," stresses Rothschild. "It requires long, gentle conversations about a lot of different scenarios. For instance, you have to ask a patient whether she wants to be tube-fed if she gets to a point where she's unable to swallow."

Physicians must also commit to staying with their patients until the end, says Rothschild. "Because most of us are uncomfortable with death, people stop visiting for all sorts of reasons. When the physician disappears, too, then that really heightens the patient's sense of abandonment."

Not every patient will choose hospice as an option, says the Reverend Laurel Burton, ThD, chairman of the Department of Religion, Health and Human Values. For example, some patients, particularly younger people, may



**"A lot depends on how much you want to fight for your life."**

The Reverend  
Laurel Burton, ThD

not ever be ready to call hospice, he says. "A lot depends on how much you want to fight for your life. For some people not calling hospice is a way of fighting for your life," says Burton.

Ultimately, the choices patients and their families make when they are dying, as in life, are extremely personal, says Nash. To meet peoples' different needs, Rush Hospice Partners is exploring ways to provide tailored services, says Nash. For instance, the hospice is working with Rush Home Care Network and other home care agencies to identify ways to provide end-of-life information and support, such as spiritual counseling, before a patient enrolls in hospice.

Eight months after his wife died, Larry Rogers stays busy after work with church activities and volunteering. But it's obvious from the way he talks about his wife how much he misses her. "The nurses at Rush Hospice told me story after story of how Sharon could walk into a situation where someone had just died, and through levity or prayer, help calm everyone down. Other times, she would just cry with the people because that's what they needed."

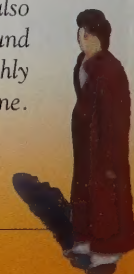
These stories about his wife made Larry more aware of the remarkable woman he married 32 years ago — of her many dimensions, some of which he never really knew, he says. "When you're with people all the time, you start to take them for granted. Sharon's death has made me take a deep look at all my family and friends. This whole experience has made me appreciate them more." ■

Rush's third annual conference on end-of-life issues will be held next May 15 and 16. Beginning next February, Rush is also sponsoring the Roger C. Bone, MD, Memorial Grand Round Lecture Series on Palliative Care, which will feature monthly lectures by nationally known experts on end-of-care medicine. For more information, call (312) 942-5580.



## Preparing for the end of life

- Talk with your family about your values and what's important to you before a crisis occurs. Make it clear what you would want in a medical emergency. For instance, in what situation, if any, would you want to be put on life support, such as a ventilator?
- Explore your spiritual or religious views. Studies have shown that spiritual or religious beliefs significantly help people cope with cancer and other diseases.
- Ask your physician what his or her philosophy is regarding life support measures and the care of dying patients. Consider whether they match yours.
- Complete a durable power of attorney for health care and share it with your spouse, family and doctor. This will help clarify your wishes at the end of life. For information, call Rush Hospice Partners at 800/994-9400.
- If you or a loved one develops a terminal illness, insist on clear, open communication with your physician about your medical options. Ask about comfort measures, including pain control. Keep hospice in mind as an option.





# Reflections on End-of-Life Care

■ by Marie Mahoney

Suzanne LaFollette, MD, entered my life shortly after my husband, Paul Harris, had been diagnosed with terminal cancer. When he died last February, Paul had been under her care for a little more than a year. During that time, she came to epitomize for me the figure of the “good doctor.” She faced every crisis with patience, courage and sensitivity. It was clear — always — that she understood what it meant for us as a family to suffer through this ordeal. In the end, her humanity became as important as her obvious expertise as a physician. In fact, they became intertwined.

**Marie:** When I first met you, I was struck by your air of authority. I kept expecting you to say, “These are the things I’m going to do to save your husband’s life.” In a sense, then, no conversation with you was ever complete, because I always expected something you couldn’t deliver.

**Dr. LaFollette:** That’s one of the pressures of being a physician. Hope is one of the most important things we have as human beings, and the need to have hope does not stop as people near death. But people may hope for different things. When I feel that we have nothing further to offer in terms of being able to cure an illness, I try to help the person shift goals from the goal of winning over the disease to the goal of doing everything possible to make the most of the time left.

**Marie:** When Paul was hospitalized, residents and medical students dutifully came around and took his medical history. It was very difficult for me to have to listen over and over to a story whose punch line was, “And, now you find me here, waiting to die.” But, more than that, I felt the information they were looking for was beside the point. I wonder if they could have been learning something else from a dying patient.

**Dr. LaFollette:** In a teaching hospital there’s bound to be conflict between what physicians with no experience with patients need to learn and what patients need. What we need to do as attending

physicians, and what nurses do particularly well, is to continually remind residents about what they’re doing.

“What are our goals? What are we trying to do in this particular situation?” Maybe the blood pressure is not important. Maybe the serum sodium level today is not important. Maybe it’s more important to spend the limited time I have with this patient on this day focusing on how he or she is feeling, instead of focusing on laboratory values.

I remember an experience I had when I was working on the cancer floor as an intern here. I walked into a room where a woman was lying in bed, obviously very ill, unable to move and in a great deal of pain. I asked her, “Is there anything I can do to help you feel better?” I expected her to give some kind of medical answer. But she said, “Could you rub my feet?” That really opened my eyes.

**Marie:** I’ve often said that there are no euphemisms in your vocabulary. I wouldn’t say you were ever harsh, but you were never evasive.

**Dr. LaFollette:** It’s hard to know the right time to start talking about end-of-life issues. I try to start talking about it as early as possible in an overall sense. I do that by continually emphasizing the goals of treatment. And every time we take the next step in treatment, it’s an appropriate time to talk about where we’re going. I would never say to a patient, “There’s nothing more we can

do for you.” There’s always something, but the something changes.

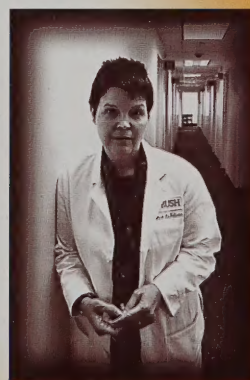
**Marie:** In our dealings with healthcare professionals, there were times when I just wanted to hear someone say, “I’m sorry you’re having to deal with this.” Sometimes I felt people took a defensive stance, as if to say, “It’s not my fault you got cancer, don’t blame me.”

**Dr. LaFollette:** If we think we’ve failed when we haven’t cured patients, if we don’t look at death as something that inevitably happens to everyone, then we are defensive. Our guilt at having failed gets in the way of reaching out to people.

It’s not our success, our personal success, when someone is cured — we’re a part of helping someone, but they’re not better because of us. And when people die it’s frustrating and sad that we can’t do more, but it’s part of a process that’s much bigger than we are. ■

**“I would never  
say to a patient,  
‘There’s nothing  
more we can  
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There’s always  
something, but  
the something  
changes.”**

Suzanne LaFollette, MD







# Practicing for Life after Transplant

■ by Maggie Kennedy

If Alonzo and Cecil can show that they are able to care for themselves, they will prove to their doctors that they're mature enough to handle what they each want: a new kidney.

**T**ry limiting what you drink to three glasses of water or juice a day. Alonzo and Cecil, two teenagers with chronic kidney failure, will tell you how hard this is. Because the teens' kidneys no longer do their job — filtering water and unwanted substances from their bodies — the boys come to Rush for dialysis three times a week. The dialysis machine operates like an artificial kidney, removing waste products from their bodies that can slowly poison them.

Alonzo and Cecil know that watching what they drink — as well as taking their medications and showing up for dialysis — is an important part of dealing with their disease. But these are heavy responsibilities for teenagers.

The two friends joke about how they mess up sometimes, but a tension between them betrays the truth: This is a test of sorts, a rite of passage. If they can

*Alonzo (background) practices with his brother Carlton. The two brothers receive dialysis at Rush.*

Photo: Andrew Campbell



show that they are able to care for themselves, they will prove to their doctors that they're mature enough to handle what they each want: a new kidney.

### Compliance and Maturity

"You need absolute compliance for a transplant," says Stephen Jensik, MD, PhD, a kidney transplant surgeon in Rush's Liver, Kidney and Pancreas Transplant Surgery Program. "Teens who are unwilling to take their medications lose their kidneys. So, maturity is just as important as medical readiness."

Both Alonzo and Cecil developed kidney disease in their teens as a result of a hereditary disorder, focal segmental glomerular sclerosis. A transplant will significantly improve their chances. Children and teens have a near normal life expectancy after a kidney transplant, while those on dialysis face a 10 percent risk of dying each year.

For the two teens, a new kidney also represents simple freedoms, like downing a glass of water whenever they're thirsty. It would also free them from having to sit through 15 hours of dialysis a week, leaving them with more time for school and work, as well as their common passion — music.

After they met at Rush, Alonzo and Cecil learned that they both played the drums in their churches' gospel bands. It wasn't long before the two teens were jamming together, along with Alonzo's 20-year-old brother, Carlton, who also receives dialysis at Rush.

All three hope to make it as full-time musicians some day. "Being a musician is what I always wanted to do," says Cecil, 18. "Ever since I was 3 years old, and I used to beat on pots and pans." Alonzo, 18, grins and shakes his head in agreement.

But the thing that would help make their dreams possible — a kidney transplant — brings on a whole new set of responsibilities. "Even if you get a transplant, you aren't actually cured," says Nicole Becker, MD, pediatric nephrologist. "They'll need to take medication every single day of their lives. They can't just ignore it."

### Pills, Pills, Pills

One of the hardest parts about getting a transplant is the amount of pills patients must take — more than 20 a day. Forgetting to take even one can be deadly. Besides this, some of the pills, such as steroids and anti-rejection medication, have side effects that any peer-conscious teenager would find troublesome. In most cases, a patient's face and body swell. Others grow excess hair on their bodies or have increased acne.

"If the kidneys are not your regular kidneys, every day is a risk," Cecil says. "They're always trying to fight you, and if you miss taking your pills one day, there's always the risk of losing a kidney."

### Dealing With Kidney Disease

Having kidney disease does not always lead to dialysis. The majority of children

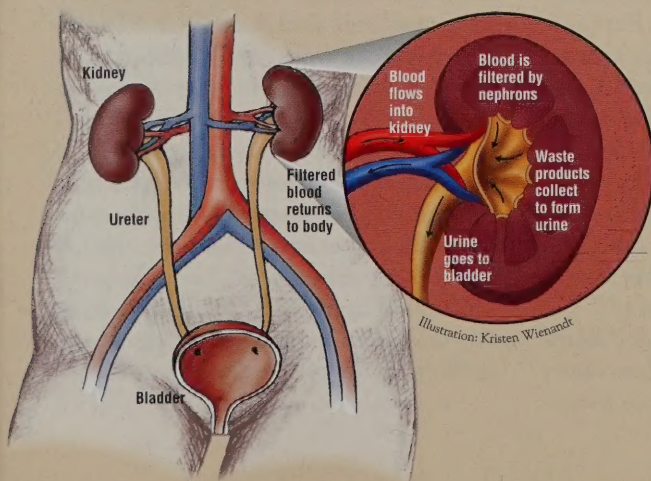
**Children and teens have a near normal life expectancy after a kidney transplant.**

seen at Rush are in earlier stages of the disease, and their kidneys still function fairly well. Many children develop the disease as a result of an injury, infection or other medical problem. Others are born with damaged kidneys.

When Cecil first developed the disease, his mother thought he'd caught the stomach flu. When his vomiting persisted, she brought Cecil to the doctor and learned he had a kidney problem. He was put on several medications, but the disease progressed and he had to go on dialysis two years later.

"We try to figure out if there is anything we can do to stop the disease process and make the kidney last as long as possible," says Christopher Clardy, MD, director of Rush's pediatric kidney program. Typically this translates into medications and diet changes.

In many ways, Alonzo and Cecil are lucky that they developed the disease in their teens and had a chance to grow properly. Unlike many children in the program, they are full height and have strong bones. Infants or young children who develop the disease are often short for their age and have other developmental problems.



## DETECTING KIDNEY AND URINARY TRACT PROBLEMS

The kidneys are a vital part of the urinary tract. Blood enters the kidneys through the renal artery and flows over thousands of tiny filters, called nephrons. These nephrons absorb the water, salt and nutrients the body needs. Everything else is excreted as urine, which is stored in the bladder until a person urinates.

Signs of a kidney problem include:

- ✓ Bloody or tea-colored urine
- ✓ Foul-smelling urine
- ✓ A change in the amount or frequency of urination
- ✓ Pain or burning while urinating
- ✓ Bedwetting after age 5 or 6
- ✓ Excessive nausea or cramping

If you or your child experience any of these symptoms, see a doctor.



At times, watching over the children's health involves as much bureaucracy as medicine.

"When children have kidney disease, chemicals like phosphorous and acid build up in their blood and dissolve their bones," says Clardy. "The kids don't grow. If you don't treat these things, the children can also get clouded mentally and don't do well in school."

To help counteract these problems, Clardy and Becker prescribe growth hormones as well as various minerals and vitamins. They also meet frequently with the nurses, dietitian and social workers in the program and consider ways to improve outcomes for all the children.

For instance, a few years ago, clinical coordinator Dori Schaer, RN, realized that many children on dialysis were being asked to take more than 30 pills a day. Realizing that few children could comply with such a regimen, the team found ways to reduce the number of pills taken orally.

For example, many children on dialysis are anemic, or have a low amount

of red blood cells, and need to take iron to counteract this problem. "We were asking the kids to take three iron pills a day," says Schaer. "Well, they

weren't. Now we're giving them iron via IV once a week when they're on dialysis, and the kids are healthier," she says.

As a result of the team's careful monitoring, the program's outcomes have significantly improved over the last several years, surpassing those of other pediatric kidney programs in areas such as proper nutrition and control of high blood pressure.

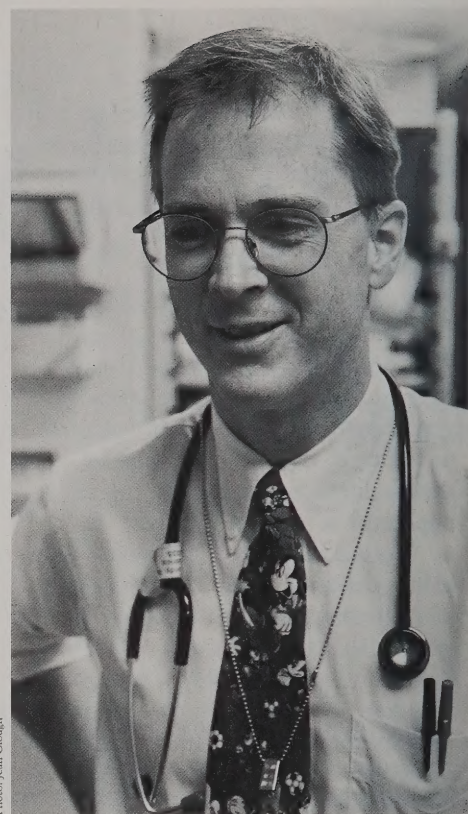
### Cutting Through the Red Tape

At times, watching over the children's health involves as much bureaucracy as medicine. The majority of children in Rush's program are uninsured or on Medicare or Medicaid. Making sure these children receive the care they need involves many phone calls to insurers and social service agencies. Rush's close affiliation with Cook County Hospital helps. Clardy, who is also director of County's pediatric kidney program, helps arrange for free checkups and tests for many of the children.

Because of their backgrounds, many children in the program are dealing with social problems that match their medical ones. For instance, one girl told Clardy that she hides out in the stairwell of her building — the only spot safe from gunfire — when gang wars break out.

Cecil, Alonzo and Carlton have

Photo: Jean Clough



*Christopher Clardy, MD, directs Rush's pediatric kidney program.*

avoided many of the hazards of growing up in the inner city, like gangs and drugs. A trip to Alonzo's and Carlton's church reveals a lot about how they've grown into such decent young men. Surrounding the church are gutted apartment buildings and vacant lots, but inside, everyone is greeted by the sweet sounds of the gospel choir and a warm handshake from the Reverend Spivey, Alonzo's grandfather.

Alonzo and Carlton are there several times a week — either in church service or practicing with the church's gospel band. Cecil comes by sometimes to practice as well. Both Carlton and Cecil were featured on the band's last compact disc, and Alonzo hopes to play on the next one.

In a way, the three young men are learning the same lesson through their music as they are managing their disease: Few things come easy. "Playing in the band is a lot of hard work," says Carlton. "Sometimes you've got to practice a song over and over. But it's worth it when you get it right." ■

Photo: Andrew Campbell



*Cecil, a teenager in Rush's pediatric kidney program, discusses his progress with Linda Strzempek, RN.*



You can fit a lot more than basketballs and badminton nets in the storage room of a gymnasium. Just ask Maria Brown, DO, a Rush family physician, who has been running a homeless clinic out of one for the past year.



# No Appointment Needed

Treating Chicago's Homeless with Respect

by Amanda Temple

**B**rown is the medical director of Pilsen Homeless Services, a clinic developed by Rush family practitioner Steven Rothschild, MD, and community activist Sister Karen Bernhardt to provide medical care and support services to the homeless in Chicago's Pilsen neighborhood.

Operating out of a storage room was not what Sister Karen and Rothschild had originally envisioned. For many years, Sister Karen had been bringing homeless people to the neighborhood clinic where Rothschild and Brown practice. As more patients turned to Sister Karen and Rothschild for help, the two began developing a

plan to secure the funding and space to meet the community's growing need. With support from the Chicago-based Washington Square Foundation and a volunteer crew of Rush medical and nursing students, the original clinic opened in a homeless shelter on 18th Street in 1994.

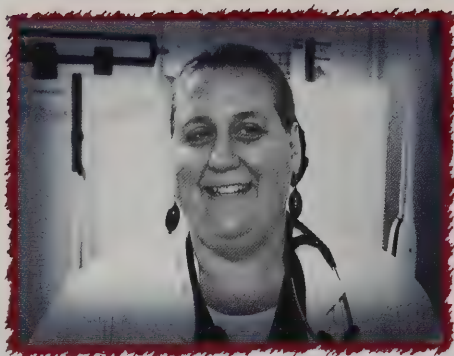
But last summer, the homeless shelter closed, and the clinic was forced to move to the only available space it could find and afford: the storage room of a neighborhood gym.

The change of venue and loss of square footage didn't stop the flow of patients. A self-described traffic cop, Brown manages to find enough room

in the clinic's cramped quarters for two patients at a time, two beds, a crew of students, shopping bags full of toothbrushes and deodorant, and all the donated pharmaceutical supplies two filing cabinets can hold.

Fitting into the social and cultural fabric of the tight-knit Pilsen neighborhood has also been an important part of the clinic's development over the past two years. The community, situated just southeast of the Medical Center, has a large homeless population. And for more than 100 years, Pilsen has been a port-of-entry community for Spanish-speaking immigrants. "People who are homeless often gravitate to communities where their language is spoken," Brown explains.





*Rush family physician Maria Brown, DO, volunteers as the clinic's medical director.*

After almost three years in operation, and despite the abrupt relocation, the clinic does what many consider impossible: maintains a core of regulars who return for follow-up care, often bringing sick friends and relatives with them. Getting homeless people into any sort of routine is difficult, especially when drug and alcohol abuse enter the picture. "The fact that patients come back — sometimes just to report their progress — says a lot about the community's acceptance of the clinic," says Sister Karen.

Brown attributes much of this acceptance to the clinic's community health advocates, who diligently comb the streets — visiting food kitchens and homeless shelters or searching under

expressway ramps — to find homeless people who need the clinic's help.

"Sometimes it's hard to know who would come into the clinic and who would be offended by my asking them to," says Roberto Cintron, the clinic's current community health advocate. "But that's the chance I have to take to make sure that everyone who needs help knows where to get it."

Nevertheless, the 27-year-old has learned not to push too hard. "There's a line I don't cross; there's a reaction I see in their faces that tells me that no amount of talking is going to get them to get help," he says of the lesson he learned the hard way after being physically threatened.

Cintron is an expert in juggling tasks. When he's not looking for patients under expressway ramps, he's searching for supplies, serving as a Spanish interpreter or checking the voice mail. "Since I was a kid, I've been taught to help people."

"I don't know what we'd do without Roberto," Brown says, as Cintron takes information from a Spanish-speaking patient. "By just being visible and accessible, he eliminates a lot of fears people may have about asking for help."

The clinic shares its quarters with El Centro, a community service agency and a common meeting place in Pilsen. This

makes a trip to the doctor more familiar for those who may find a sterile, quiet office unwelcoming. Patients en route to the clinic are greeted by signs for job training, food drives and AIDS prevention. Neighborhood kids shoot hoops a few yards from the Muzak-free waiting area, and every patient is personally welcomed by an "Hola" from Brown.

At the clinic, patients share more than just their aches and pains. They talk candidly about the frustrations and fatigue of life on the streets. Their medical conditions corroborate their plight. Common problems include scabies from sharing mattresses in homeless shelters, frostbite from exposure to extreme cold, high cholesterol levels from eating cheap and greasy food, and foot problems from an unhealthy combination of old shoes, poor hygiene and long hours of standing.

"Our goal is to break the cycle of homelessness and poverty instead of just putting Band-Aids on it," Brown says. Often that means pointing — even pushing — patients in the direction of more help, like an HIV program or an employment agency. When patients require hospital treatment or longer-term care, Brown pulls out her photos of Interfaith House, a respite-care facility that provides care to the homeless with help from Rush nursing students.

**"We are what we are, we have what we have, and we do whatever we can do. One thing we can always do is treat people with respect."**



*Melissa Simon, a Rush Medical College student, examines a patient.*





Photo: Jean Clough

**“Our goal is to break the cycle of homelessness and poverty instead of just putting Band-Aids on it.”**

*Vicki Samuels, a first-year resident in Rush's Department of Family Medicine, and Roberto Cintron, the clinic's community health advocate, talk with a patient.*

“Empty promises are pretty common for our patients. It's good to show something concrete,” Brown says.

Still excited about the office's newest accessory — voice mail — the staff operates without the gadgets and gizmos their fellow clinicians rely on in better equipped facilities. Although the technology is less advanced, the supplies fewer and space smaller than most doctors' offices, the level of professionalism and respect is the same, Brown says.

“We are what we are, we have what we have, and we do whatever we can do,” Brown says, while rummaging through the cabinet for some ointment

for a regular. “One thing we can always do is treat people with respect.”

The steady flow of patients, between 15 and 20 a day, is met by a steady flow of Rush students. The volunteers are primarily first- and second-year medical students and residents from the Rush Department of Family Medicine and nurse practitioners in training.

While the setting isn't traditional, the lessons learned are the basics of good medicine, says fourth-year medical student June Lee. “The one-on-one interaction with patients and exposure to a variety of circumstances immerse you from the very beginning,” she says.

“The patients are your best and, often, only source of information about their health. You can't just call their former physician. You have to listen.”

The most important lesson for both Brown and Lee didn't come from the pages of a medical textbook, but from the faces of their patients. “You become humbled when you see the strength that people have under such incredibly adverse situations,” Brown says, proudly recalling those who have broken out of the cycle of homelessness and still stop by to report their progress. “They're the heroes in this story. They've put a face on the homeless.” ■

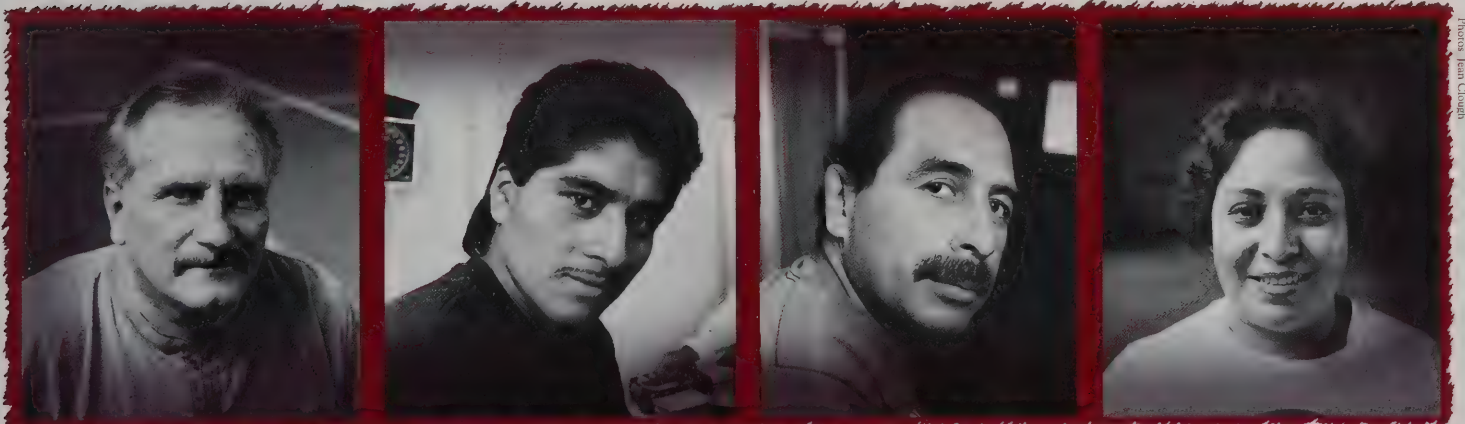


Photo: Jean Clough

**“They're the heroes of this story. They put a face on the homeless.”**





# Caring for the smallest INFANTS

■ by Tracy Binius

What  
happens  
in the first  
20 minutes  
of life can  
make or  
break  
the next  
80 years.

Jennifer Morgan's pregnancy didn't go as well as she and her husband, Dan, had hoped. After weeks of bed rest to stave off preterm labor, she found herself in the delivery room about three months before her due date, ready to give birth to twins.

As soon as Ethan was born, weighing less than two pounds, the neonatologist and staff went to work, coaxing the baby to breathe. Soon Ethan turned bright pink, a sign that he was getting the oxygen he needed. Ten minutes later, Joshua was born, and the team was back in action.



What happens in the first 20 minutes of life can make or break the next 80 years, says Robert Kimura, MD, director of neonatology. Ethan and Joshua had a very important task after they left the womb: taking their first breath of air. While full-term babies usually accomplish this without problems, premies often have trouble because their lungs are not fully developed. The longer newborns go without oxygen, the greater the risk that they will suffer permanent brain damage, seriously hampering their ability to walk or perform well in school.

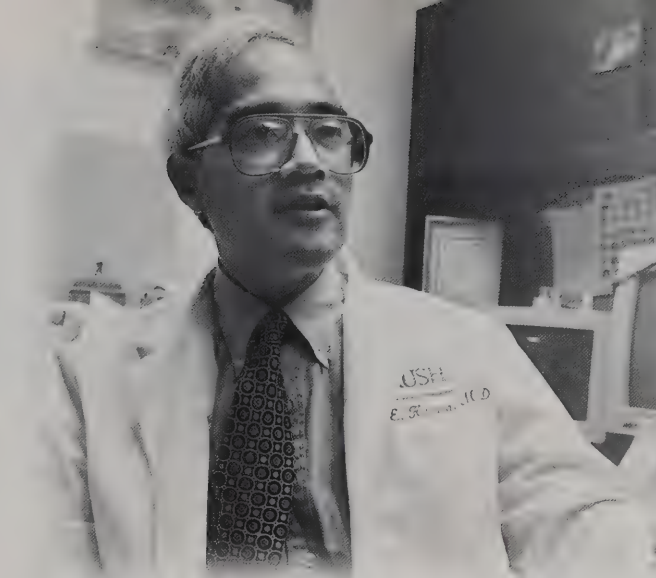
To ensure that premature infants receive fast, experienced care, Rush became the first hospital in the Chicago area to have a board-certified neonatologist in-house 24 hours a day. Whenever an expectant mother is admitted for a high-risk delivery — whether at 1 a.m. or 1 p.m. — a neonatologist is close by.

This arrangement — as well as improved medications and other treatments — has contributed to Rush's success with premature and sick infants. Babies who weigh about a pound and a half at birth now have a greater than 60 percent chance of surviving; that's up from 38 percent since 1990.

Photo: Andrew Campbell



Jennifer Morgan with her twins, Joshua and Ethan, at home.



Robert Kimura, MD, director of neonatology at Rush.

**Rush became  
the first hospital  
in the Chicago  
area to have a  
board-certified  
neonatologist  
in-house  
24 hours a day.**

Photo: Jean Clough

These babies are also going home sooner — in less than 100 days on average, compared with 200 days in 1990. This is about 25 days sooner than premature infants discharged from other top neonatal units in the country, says Kimura, citing comparative data.

The battle to send these infants home healthy and safe begins long before they are born. As one of the 10 medical centers in a statewide perinatal network, Rush provides care to hundreds of women with special pregnancy needs each year. Rush obstetricians aggressively treat expectant mothers at risk for early delivery with various medications that hold off contractions, fight infections and help the fetus develop.

Jennifer's obstetrician referred her to Rush when she showed signs of an early labor at 21 weeks. Rush physicians put her on bed rest and prescribed medications to hold off her labor. A few weeks later, she was given steroids, compounds that stimulate organ and muscle growth, to help her babies' lungs mature faster in the womb and protect against other problems.

"I'm very fortunate that the doctors got me down to Rush and gave me steroids. I'm convinced it gave my babies a better chance," Jennifer says.

After Ethan and Joshua were born, they were transferred to Rush's 45-bed neonatal intensive care unit, where they spent most of the next several weeks in incubators hooked up to monitors, IVs and respirators. Half the size of full-term babies, the twins were carefully monitored by neonatal nurse practitioners who watched for breathing problems, infec-

tions and other complications.

These nurses, who have master's degrees and specialized neonatal training, watch over all premies with special needs — like Ethan and Joshua, who weighed less than two pounds each — 24 hours a day. "These nurses bring up-to-date knowledge on how to manage a baby and intervene during a crisis," says Diane Gallagher, MS, RN, unit nursing director.

Fortunately, Ethan and Joshua came through their first two months without any major complications. The biggest scare came early, when Jennifer and Dan learned that Joshua had a heart murmur. But Rush neonatologists successfully corrected this with medication.

A spirit of cooperation and innovation exists among staff on the unit, note Kimura and Gallagher. This atmosphere has made it easier to implement ideas such as skin-to-skin bonding between babies and parents.

Almost every time Jennifer and Dan visited, they each held one of the unclothed babies on their bare chests. "It was wonderful. It was the only time we could hold them when they were that small," says Jennifer.

After visiting the unit every day for two and a half months, Jennifer and Dan buckled Ethan and Joshua into their brand-new car seats and headed home last August.

Now, Jennifer and Dan are busy with more typical worries of new parents, such as telling their newborn twins apart. "We have to look really close," says Jennifer. "They each have a few marks left from the monitors at the hospital. Right now, that's how we tell Ethan from Joshua." ■



# Take it from Mom: BREASTFEEDING BENEFITS PREEMIES

It's nature's perfect food. Mothers and scientists have known this for years. Breast milk has all the necessary nutrients to give babies a healthy start. Breast-fed babies have fewer infections and allergies and fewer bouts of diarrhea than bottle-fed babies. But what happens when a baby is born too small or too weak to feed at the breast?

Paula Meier, RN, DNSc, has dedicated her career to finding ways to ensure that premature babies — those born before 38 weeks gestation — get that important nutrition. Meier is director of the Rush Neonatal Intensive Care Lactation Program, a research-based program that educates mothers of premature infants about breastfeeding. Meier's work is partially supported by a grant from the National Institutes of Health.

Breastfeeding is different for premature babies because they don't have the

■ by Lisa Spengler

strength or coordination to suckle like a full-term infant, says Meier. To breastfeed their preterm infants, mothers must pump milk from their breasts several times a day.

The baby is fed the milk through a tube that passes from the mouth or nose into the stomach. If a baby is stable enough, he or she can suckle at the mother's empty breast during feedings. Research shows that this sucking calms and soothes a premature baby, and that it triggers the production of digestive enzymes that make it easier for a baby to digest milk, Meier says.

"Preterm milk is tailor-made for premature babies," Meier says. "When a mother delivers prematurely, her milk differs in composition from that of a mother who delivers at full term." For instance, the milk contains higher concentrations of antibodies to fight infection. Preterm milk also has a different type of fat than full-term milk, which is thought to promote healthy eye and brain development.

To help speed the development of premature infants, Meier and her colleagues fortify preterm milk with extra calories and fat from ordinary breast milk using a technique called lactoengineering. "Very tiny babies need high calories to grow but cannot tolerate high volumes of milk," says Meier. So far, Meier and the staff have noticed marked improvement in the weight gain of infants who are fed lactoengineered milk.

Gladys Thomas' dedication to breastfeeding required her to drive 50 miles from Elgin every day to ensure that a fresh supply of milk was available for her son, Kendall. The environment in the Rush neonatal intensive care unit offered Thomas the chance to sit beside Kendall's incubator while she pumped milk. She could also hold him naked against her bare chest while he was feeding from a tube.

Spending long hours at the hospital can be stressful for a mother already wor-

Breast milk is nature's perfect food. But what happens when a baby is too small or too weak to feed at the breast?



Gladys Thomas holds her son, Kendall.

ried about the condition of her preterm infant. So at Rush, mothers are encouraged to share their feelings with staff and other breastfeeding mothers in a weekly group meeting of the Rush Mothers' Milk Club. Mothers discuss their goals and concerns about breastfeeding, and offer support and assistance for each other.

Thomas continues to breastfeed now that Kendall is home. She also makes a point to schedule Kendall's checkups on days when the Mothers' Milk Club meets. "I think Kendall has done really well because of my breastfeeding," says Thomas. "I want other moms to know that." ■

**To help speed the development of premature infants, Meier and her colleagues fortify preterm milk with extra calories and fat.**



Paula Meier, RN, DNSc, talks with a new mother.





# Rush MD

The Alumni Association of Rush Medical College

Rush Medical College

Fall / Winter 1997

## Alumni Raise Over \$7 Million in Scholarship Funds

**H**elping bear the financial brunt of medical education for promising medical students was the Alumni Association's specific goal during the Campaign for Rush, which ended in May (see the *Rush Record*, page 20).

In recent years, the high cost of education — average tuition at Rush surpasses \$20,000 annually — has dissuaded many promising students from pursuing medicine or forced them to drop out of medical school. Thanks to the support of alumni, the Association was able to raise over \$7 million in scholarship monies during the Campaign to help these students.

Below are the stories of several alumni who established or contributed to scholarship and endowment funds that directly help medical students. We want to thank all alumni who generously supported the Campaign. Every gift, whatever its size, is an investment in Rush's people and programs.

### Assisting worthy students

Jennifer Brown was thrilled when she learned she had been accepted to Rush Medical College three years ago. But like many aspiring physicians, she has found that meeting the high cost of medical school poses as big a challenge as her studies.

Fifty years ago, Hans "Doc" W. Lawrence, MD '29, was also a struggling

medical student. Remembering these lean years, he and his wife established the Esther H. and Hans W. Lawrence, MD, Endowed Medical Student Assistance Fund. Jennifer Brown is the first of many students who will benefit annually from the Lawrence's generosity.

"As a student,

Doc struggled to raise money for his tuition, and he never forgot how difficult this was," explains Fred Benadum, Dr. Lawrence's longtime friend and financial advisor. "This fund was his legacy — his way of trying to make things easier for other struggling students."

Dr. Lawrence, who died in August 1996 at age 96, donated more money to Rush Medical College than any other alum in the school's history — more than \$2.75 million in total.

"Doc" was born in Alsace-Lorraine, France, in 1909 and moved with his family to Wisconsin when he was eight. After graduating from Rush and serving in the armed forces during World War I, he specialized in occupa-



Hans Lawrence, MD '29 and his wife Esther.

tional medicine. He worked for Proctor & Gamble for many years, and was the company's medical director from 1947 to 1963.

Dr. Lawrence's main research interest was cholesterol control. He helped establish one of Chicago's first lipid departments, originally sponsored by Proctor & Gamble.

"Everything I've learned about Dr. Lawrence leads me to believe he was a very generous man who was always giving back to Rush," says Ms. Brown, a fourth-year student who plans to become an oncologist. "I feel privileged to benefit from his gift, and hope someday I will be in a position to repay the favor."

*continued on page 2*



## Promoting primary care research

For many primary care physicians, research typically has to take a back seat to patient care. Busy schedules and lack of funding are just a few of the barriers primary care physicians face when pursuing scientific interests.

Now, thanks in part to the generosity of Richard Melcher, MD '75, and his mother, Doris, Rush has launched the Primary Care Scholars Initiative aimed at helping future and practicing primary care physicians to conduct important research. The Melchers established the Doris Melcher and Richard Melcher Family Endowment for primary care to help fund this initiative.

"Many of the best and brightest are attracted to primary care," says Dr. Melcher. "But many of these doctors feel like they have to give up their interest in academic medicine. This initiative will allow them to continue research and keep their own practice. It offers the best of both worlds."

Sponsored by the Rush Primary Care Institute, the initiative has several goals:

- Help practicing primary care physicians design and participate in research studies.
- Develop educational offerings for Rush medical students, residents, fellows and faculty that will help them develop their research skills.
- Increase communication and exchange of scientific work and ideas across the primary care disciplines.

A specialist in geriatrics, Dr. Melcher first became interested in research as a young physician when he heard about a primary care physician from Georgia who practiced during the week and conducted research on weekends. This physician ended up discovering that African Americans have a higher incidence of stroke, a major finding that has since led to more aggressive prevention strategies.

Dr. Melcher pursued a fellowship at the University of North Carolina, Chapel Hill, in which he spent a third of his time engrossed in primary care research. In the years since, he has participated in various research projects, including a national study on Alzheimer's.

"When physicians conduct research, I think it makes their patients look at them as somewhat special," says Dr. Melcher. "I think it's important to a patient that his or her physician is on top of the literature, and is contributing to that literature."

## Increasing minority enrollment

Medicine is the only profession Chicago southside native Clarence Parks seriously considered since he was 7 years old. Support from the Leonidas Berry Fund for Excellence made it possible for Parks to realize his lifelong dream.

A 1930 Rush graduate, Dr. Berry was an internationally recognized authority on digestive diseases and endoscopy. He was the first doctor to perform gastroscopies at several



Leonidas Berry, MD '30

Chicago hospitals in the 1930s and 40s.

As important, Dr. Berry dedicated himself to bringing medical care to black communities that had none. He also paved the way for African Americans interested in medicine as a career. Dr. Berry was the first African-American physician at Michael Reese Hospital and Medical Center and one of the first African Americans to be admitted to the American Medical Association.

In 1993 — three years before his death — Dr. Berry created the Berry Fund with the goal of drawing more minority students into medical careers. African-Americans are still underrepresented in the profession.

In June, Clarence Parks graduated from Rush Medical College and is now pursuing a dual residency in internal medicine and pediatrics at Wayne State University's Detroit Medical Center.

## Expanding scholarship assistance

Quietly committed to supporting her alma mater, Helen Holt, MD, '34, was an active member of the Alumni Association throughout her life. She served on the Executive Council and was the first to volunteer for many ongoing committees.



Richard E. Melcher, MD, '75 and his mother Doris.

*continued on page 6*



# Alumni Support Is Vital to the Progress of Rush Medical College

Erich E. Brueschke, MD, The Henry P. Russe, MD, Dean of Rush Medical College

**A**s a Rush graduate, you earned a degree from a school known for excellence and innovation — a degree that will increase in value as Rush's reputation grows. But commencement was just the start of your relationship with Rush Medical College. As an alum, your continued support and involvement is essential to ensuring Rush's progress — and its graduates' continued success.

At graduation, you were automatically enrolled in the Rush Medical College Alumni Association, an organization that is committed to helping Rush flourish. Alumni members serve as mentors to Rush students and support programs that keep Rush at the forefront of medical education. Alumni contributions — of both time and financial support — allow us to provide innovative programs and services that enrich the learning of today's Rush students.

Pioneering educational programs made possible through your support are described in the following paragraphs.

## Student scholarships and loans

Alumni support allows us to provide scholarships and low-interest loans to promising students who might not otherwise be able to afford a medical education. By reducing student debt, alumni-funded scholarships and loans also enable more Rush graduates to pursue advanced training in the primary care fields. With medical school tuition at an all-time high — and generalist physicians in increasing demand — alumni support for this purpose is vital.

## The Alumni Exchange

This program offers a forum for Rush students to talk with alumni volunteers

about specialty choices and other issues related to careers in medicine. Held three times a year, the Alumni Exchange is a unique opportunity for students to learn from experienced Rush graduates and to forge relationships with potential mentors.

## The Peer Tutoring Program

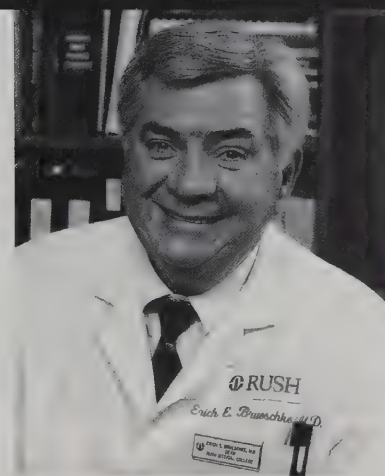
This alumni-funded program offers third- and fourth-year medical students opportunities to earn money by tutoring first- and second-year students who need extra help in the basic sciences. This program has had a measurable impact on students' academic performance.

## Clinical skills exam

Rush, Northwestern University, University of Chicago, University of Illinois and Loyola University have pooled alumni funding and faculty resources to create a unique exam that evaluates medical students' clinical strengths and weaknesses early in their medical educations. As part of this exam, second-year students are videotaped as they perform mock examinations on specially trained "patients" who exhibit standard symptoms and complaints. The results of this exam help students identify the clinical skills they need to develop in the final two years of medical school.

## International studies

Alumni contributions partially fund fourth-year students' overseas educational experiences, allowing them to complete electives in impoverished regions of Africa, Pakistan and Peru.



Students who participate in this program enhance their clinical skills and, at the same time, gain first-hand knowledge of other cultures. Last year, 12 students were able to benefit from such overseas studies.

## Conveying excellence

These are just a few of many innovative Rush programs and services made possible by alumni support. Such initiatives offer students opportunities to gain the unique knowledge and experience that helps them become truly first-rate physicians — the kind of doctors you want us to train.

As the dean of Rush Medical College, I thank those of you who support Rush for your generous contributions of time and money. Your support allows us to provide academic support and opportunities that allow our students to develop the critical intellectual and caring skills that are essential to the best physicians. I also invite other alumni to get involved in the Alumni Association. With your help, we can ensure that the name "Rush" continues to convey excellence and innovation in medical education for years to come. ■





Photo: Eric Werner

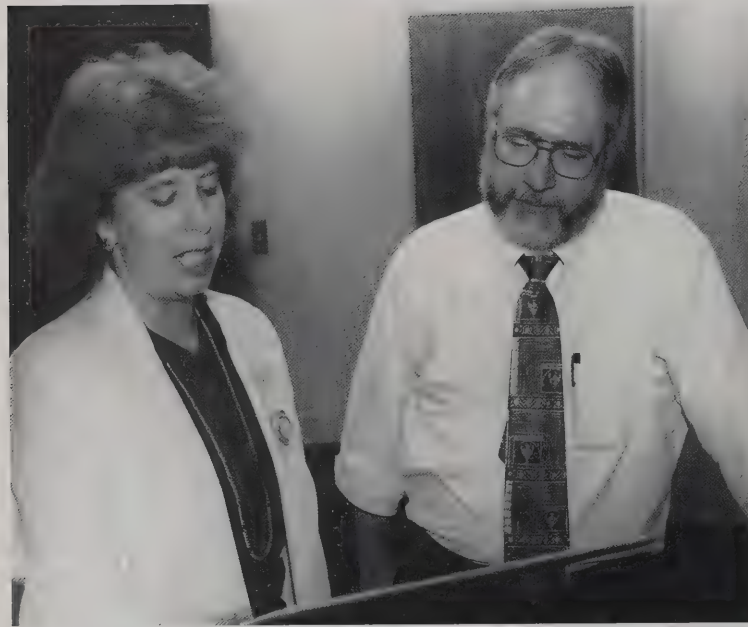


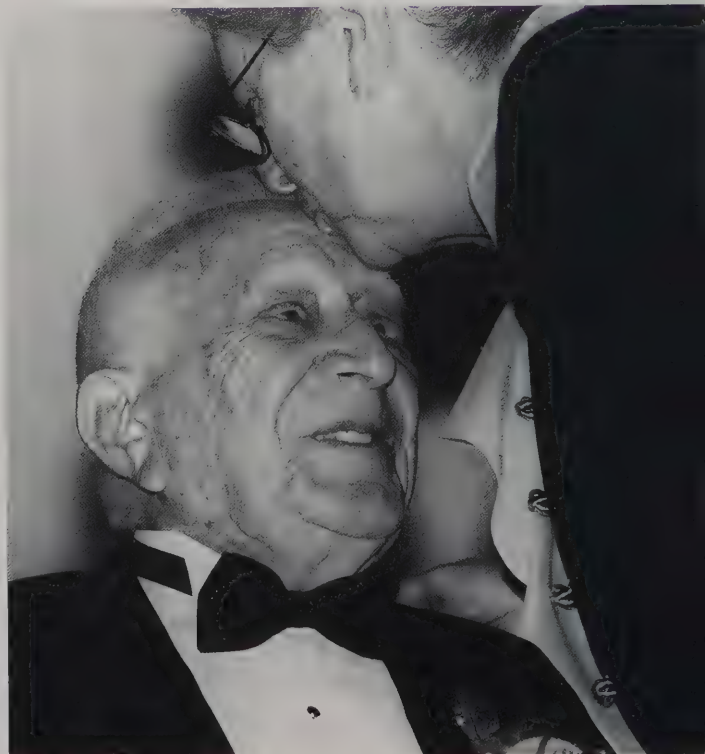
Photo: Eric Werner

Photo-top: **Joseph Bernardini, MD '75**, shares a playful moment with **Leo M. Henikoff, MD**. Dr. Henikoff is president and chief executive officer of Rush-Presbyterian-St. Luke's Medical Center. Photo-above: **Karen Weinstein, MD '83**, presents a plaque to **Thomas Bleck, MD '77**, after he spoke on mad cow disease at the Medical Grand Rounds. Photo-right: **Louis R. Wasserman, MD '36**, receives a kiss from his wife, **Julia**, after receiving the 1997 Distinguished Alumnus Award, the Alumni Association's most esteemed honor. Dr. Wasserman is widely recognized as the world's foremost authority on polycythemia, a chronic, life-threatening condition caused by an excess of red blood cells.

# Alumni Week 1997

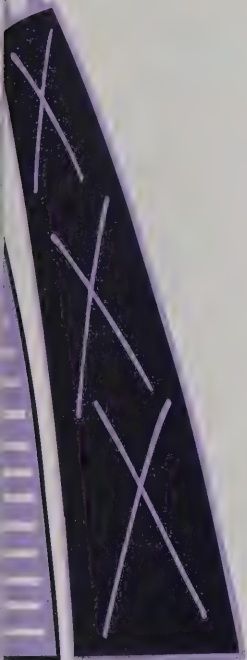


Classes of 1937, 1942, 1977, 1987 and 1997  
for a weekend of celebration





end



eunited in June



Photo: Eric Werner



Photo: Eric Werner

Photo-top left: **William Harrison, PhD**, professor of biochemistry and neuroscience at Rush, holds up his "TGIF Tie" that he wears every Friday. Both **Dr. Harrison and Karen Weinstein, MD '83**, received **James A. Campbell, MD Alumni Service Awards** this year. Photo-top right: **Steven Z. Powell, MD '97** dances with a friend. Photo-bottom left: **Joseph Pace, MD '42**, who is from Utah, carries a Chicago Bulls cap. The Utah Jazz were playing the Chicago Bulls for the NBA 1996/1997 Championship during Alumni Weekend. Photo-bottom right: New grads **Jill Pierce, MD '97**, and **Clarence Parks, MD '97**, show off their diplomas.



Photo: Eric Werner



Photo: Bruce Powell



# A Post-Campaign Challenge: Increase Support of Unrestricted Funds

Barbara Fuller, MD '76, President, Rush Alumni Association



**N**ow that the Campaign for Rush has culminated in an overwhelming success, we must ask ourselves, "What's next?"

At the fall Alumni Executive Council meeting, members expressed concern over the increasing costs of medical education and the increasing financial needs of Rush Medical College students. We all agreed that the Council needs to take a more active role in soliciting donations if we are to achieve the Association's goal: providing more dollars to help worthy students pursue their medical educations.

To this end, the Council is offering a challenge to all Rush alumni. This past year, members of the Alumni Executive Council collectively donated \$41,000 to various funds designated for student assistance. We would like to challenge all our fellow alums — as a group — to top the amount the Council donated by increasing your support of Rush Medical College this year.

The simplest way to meet this challenge is to designate your contributions as unrestricted support for

Rush Medical College alumni programs. Last year, these funds supported many worthwhile programs, including:

- Peer Tutoring, which allows students to earn money while tutoring underclassmen.
- The Summer Research Fellowship Program, which gives students the opportunity to conduct hands-on research.
- The Rush University Library, which is expanding to provide technically advanced educational opportunities, such as computer-based learning.

- The Alumni Exchange, a forum for alumni volunteers to talk with students about specialty choices, or other "hot" topics in medicine.
- The Mark H. Lepper, MD, Society of Teachers, which honors those who have received basic or clinical sciences teaching awards at Rush Medical College.

Of course, if you would like your donations to go toward another specific fund or scholarship (See some options in the story on page 1), we encourage you to do so. As always, thank you for your continued support of Rush Medical College. ■

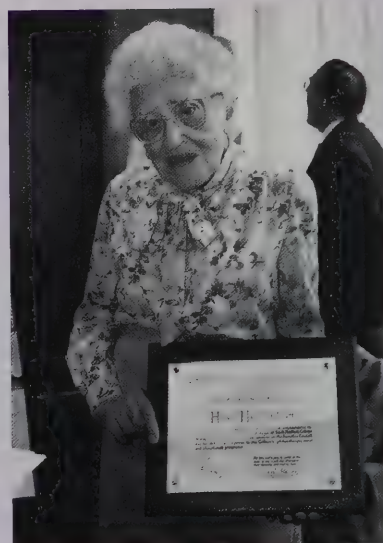
## Expanding Scholarship Funds

*continued from page 2*

"She's always there when you need her," said Mary C. Tobin, MD '77, when she presented Dr. Holt with the the James A. Campbell, MD, Alumni Service Award in 1984.

One of her final contributions to Rush was a \$25,000 gift to The Henry P. Russe, MD, Student Assistance Fund. Named for the 12th Dean of Rush Medical College, the Russe Fund provides financial assistance to deserving medical students.

A lifelong resident of the Chicago area, Dr. Holt attended undergraduate school at Northwestern University and received her medical degree from Rush in 1934. An ophthalmologist, she had offices in Chicago and Highland Park for 40 years. She was



**Helen Holt MD, '34**

also an assistant professor of ophthalmology at Northwestern University. Dr. Holt died in 1992 at the age of 91. ■



# Alumni Honor Roll by Class—Fiscal Year

## Classes '17-31

Samuel J. Pearlman, MD,  
Estate  
Alice Mary Hunter, MD  
Hans W. Lawrence, MD,  
Estate\*  
Samuel A. Scuderi, MD  
Leonidas H. Berry, MD  
Estate\*  
William S. Hoffman, MD  
Donald J. Sabbath, MD  
Jacob W. Schoolnic, MD

## Class of '32

Elena Boder, MD Estate  
George Eisenberg, MD  
William W. Pike, MD  
William J. Sweeley, MD  
Edward Howard  
Wagenaar, MD

## Class of '33

Noah Barysh, MD  
Harry C. Goldberg, MD  
Jack Levitt, MD  
Harry B. Miller, MD  
Clarence W. Monroe, MD\*

## Class of '34

Edward G. Bourns, MD\*  
Robert D. Fairchild, MD  
Maurice J. Golden, MD  
Vida H. Gordon, MD\*  
Richard E. Heller, MD  
Francis W. Huston, MD  
James W. Merricks, MD\*  
Merrill Lee Oldroyd, MD  
Alice H. Stewart, MD,  
Estate\*

Key:

\* Denotes members  
of the Benjamin  
Rush Society

**Bold** Denotes alumni  
volunteers

## Class of '35

A. Stone Freedberg, MD  
Alan P. Freedberg, MD  
Durward G. Hall, MD  
H. Sidney Heersma, MD\*  
Kate H. Kohn, MD  
Arthur M. Olsen, MD  
Irving Slott, MD

## Class of '36

Louis Belinson, MD  
Samuel J. Bolonik, MD  
Juliette M. Eliscu, MD,  
Estate  
Samuel I. Greenberg, MD  
Leo Markin, MD  
**Russell P. Sinaiko, MD\***  
Jerome H. Tucker, MD

## Class of '37

Leonard L. Braun, MD  
Louis Bush, MD  
Woodrow Wilson Eddins,  
MD  
Bernard Greenberg, MD  
Ann Harriet Huizenga, MD  
Mayer Hyman, MD  
Walter F. Jennings, MD  
Herman Kirchdoerfer, MD  
**Harold Laufman, MD**  
Emanuel C. Liss, MD  
Robert George Mindrup, MD  
John Newdorp, MD  
Leon Seidman, MD  
Thomas Andrew Slate, MD  
Hugh Henderson Steele, MD  
James David Stratton, MD  
Sidney Trubowitz, MD  
Bert J. Vos, MD

## Class of '38

Eugene Joseph Boros, MD  
Gerrit Dangremond, MD  
J. Will Fleming, MD\*  
Ralph Friedlander, MD  
Louis Linn, MD

Horace D. McGee, MD  
William Hall Orcutt, MD  
Frederick A. Schurmeier, MD  
Eric E. Simonson, MD  
Fletcher S. Sluder, MD  
Tetsui Watanabe, MD

## Class of '39

Wilbur George Braham, MD  
Emma G. Work Burt, MD  
Jack Carl Dysart, MD  
Barton Maxwell Eveleth, MD  
Robert Brown Henry, MD  
Maria Kraus Kramer, MD  
Thomas William Sugars, MD  
Anthony Cyril  
Yerkovich, MD  
Vern Lauer Zech, MD

## Class of '40

E. Gordon Behrents, MD  
Fred Wylie Clausen, MD  
Gordon Hall Congdon, MD  
Frederic A. de Peyster, MD\*  
Gene William Farthing, MD  
Ryland Marcus Jacobus, MD\*  
Arthur J. Koven, MD  
Edward Lawrence Laden, MD  
Eugene Bowles  
McGregor, MD  
Max Benjamin Milberg, MD  
Adolph Martin Nielsen, MD  
Vincent J. Schilleci, MD  
Richard H. Sidell, MD  
Irvin S. Siglin, MD  
Roy T. Tanoue, MD\*  
Benjamin Ernest Tuch, MD  
**Richard C.  
Vanderhoof, MD**  
John Allen Watson, MD

## Class of '41

Shoichi Asahina, MD  
Harold A. Bjork, MD  
Irving Eugene Brown, MD

M. Wesley Farr, MD  
Charles M. Grace, MD  
Aaron Grossman, MD  
Alfred P. Kraus, MD  
Loren Joseph Larsen, MD  
Nathan Shlim, MD  
Blake Strother Talbot, MD  
Cleo Leo Vogeles, MD  
John W. Wichman, MD  
Vinton Hodge Wright, MD

## Class of '42

William F. Bethard, MD  
Robert Anderson  
Crawford, MD  
Joseph T. Crockett, MD  
Harold Everhard DePree, MD  
Inez Willoughby Elrod, MD  
Russell Lawrence Hafer, MD  
Edward Jordan Hagan, MD  
**George H. Handy, MD\***  
Helen Jane Hare, MD  
Kenneth T. Hubbard, MD\*  
Royal Ernest Ihrke, MD  
Frank W. Johnson, MD  
Robert E. Kirkman, MD  
Hugh Alexander  
McIntosh, MD  
Isaac Eldrew Michael, MD  
Milton E. Nugent, MD  
Joseph Leon Pace, MD\*  
**Robert A. Ryan, MD\***  
Albert J. Scherman, MD  
Edward William Schlies, MD  
Thomas M. Snyder, MD  
Eugene J. Usow, MD  
Jerome Waldman, MD  
Frederick S. Webster, MD

## Class of '73

Alan B. Bergman, MD  
Joseph D. Billotti, MD  
Michael J. Cwynar, MD  
**Floyd F. Shewmake, MD**  
Gary J. Snyder, MD\*  
Glen E. Sutherland, MD  
Edward J. Weiner, MD\*



## Honor Roll, continued

### Class of '74

#### Willie C. Blair, MD\*

John A. Campbell, MD  
David N. Campbell, MD  
Craig Dean, MD  
Donald B. Fletcher, MD  
John J. Garvie, MD\*  
Harold A. Kessler, MD\*  
Vasilios S. Lambros, MD  
Frank C. Madda, MD  
Doris J. McCulley, MD  
Walter E. Meyer, MD\*  
Stephen Paul

Montgomery, MD\*

Stephen Mueller, MD

#### Ronald D. Nelson, MD\*

Michael S. Pinzur, MD  
John A. Schaffner, MD  
John R. Schmitt, MD  
Gary Simpson, MD  
Alain J. Talyon, MD  
Lorren Weaver, MD  
Curtis R. Whisler, MD  
Larry Wilcken, MD

### Class of '75

George D. Benton, MD

#### Joseph P. Bernardini, MD\*

Stephen Bickel, MD\*  
Robert Cairns, MD  
Robert L. Cohen, MD  
Dino S. Delicata, MD\*  
William Dwyer, MD  
Glen Gabbard, MD  
Steven Gitelis, MD\*  
Henry M. Gold, MD  
Michael Gold, MD  
William F. Graettinger, MD  
Stephen R. Humowiecki, MD

Michael L. Hundert, MD\*

Jeffrey R. Kanofsky, MD

Jeffrey C. King, MD\*

Richard E. Melcher, MD\*

Kenneth A. Miller, MD

David F. Morgan, MD\*

#### R. Joseph Olk, MD\*

John Rankin, MD

Steven Rottman, MD

Harold Sand, MD

Steven Sicher, MD

Robert Tartell, MD

Paul Werner, MD\*

Joseph L. Wilhelm, MD

### Class of '76

Melody Cobleigh, MD

#### Henry Danko, MD\*

#### Barbara Fuller, MD\*

Robert N. Jones, MD\*  
Jane Grace Killgore, MD  
Howard W. Needelman, MD  
Beatrice L. Pitcher, MD\*  
Stanley Whittemore, MD

### Class of '77

Thomas P. Bleck, MD

Ernest Dale Buck, MD

Ann M. Buettner, MD

Charles Stewart

Colodny, MD

Steven M. Croft, MD

H. Gunner Deery, MD

Gary Michael Deutsch, MD

David J. Gray, MD

Marc Lorber, MD

David I. Margolin, MD

Gregory J. Mertz, MD

Timothy C. Payne, MD

Arnold Paul Robin, MD

Shelley Schuler, MD

Renslow D. Sherer, MD

Arthur James Small, MD

Daniel Jay Smith, MD

David Stair, MD

James Edward Swanson, MD

#### April H. Teitelbaum, MD\*

Mary C. Tobin, MD

John Lance Vander-

Schilden, MD\*

### Class of '78

Alpheu T. Appenheimer, MD

Robert J. Bernardoni, MD

Frederick B. Bustin, MD

Pamela Charney, MD

Diane Gomez Dahmer, MD

Richard Drimalla, MD

John C. Farrin, MD\*

#### Kim M. Fehir, MD\*

John Garnett, MD

Mario Garretto, MD

Steve B. Kalish, MD

Ezriel Edward Kornel, MD

Elliott Kroger, MD

Jeffrey Lazarus, MD

Deborah Susan Loeff, MD

Patrick J. Loehrer, MD

John W. McClean, MD\*

James McGarry, MD\*

Mary K. Palmore, MD

John T. Pappas, MD

David Andrew Racher, MD

Arvin Raheja, MD\*

David Ranz, MD

#### James E. Rejowski, MD

Paul B. Ringel, MD

Kenneth R. Roepke, MD

Lorry Glen Rubin, MD

Steven Sauerberg, MD

Donald Skor, MD

Leslie Trubow, MD

Myron Wojtowycz, MD

Fuk Chun Alan Wong, MD\*

Jacques N. Farkas, MD

Irene R. Japha, MD

Judd M. Jensen, MD

Donn Edward Johnson, MD

Richard A. Kaplan, MD

Peter Sundehl Krogh, MD

John Francis Neylan, MD

Douglas O. Olsen, MD

John P. Quinn, MD

Michael D. Schreiber, MD

Robert E. Schwartz, MD

Walter F. Siller, MD

Elizabeth M. Stone, MD

John F. Tucker, MD

Derek Van Amerongen, MD

Linda Wagner-Weiner, MD

Ronald L. Weinstein, MD

### Class of '80

Allen R. Braun, MD

Charlotte S. Brody, MD

Bruce H. Campbell, MD

Theresa M. Dabek, MD

Mary Barton Durfee, MD

Randy J. Epstein, MD\*

James W. Faulkner, MD

Mary Rascia Forman, MD

Jack Fuhrer, MD

Richard G. Hayes, MD

Jean L. Holley, MD

Andrea L. Lawless, MD

Susan T. Lyon, MD

Phillip J. Maple, MD

Wayne S. Margolis, MD\*

James E. Moyer, MD

Russell M. Petrak, MD

Leslie T. Yamamoto

Purtell, MD\*

Gail Schewitz, MD

Gregory W. Schroff, MD

John Segreti, MD

Stanley M. Shapiro, MD

Glen D. Solomon, MD

Rhonda E. Stein, MD

Daniel J. Sullivan, MD

Robert W. Trauscht, MD

Peggy E. Warren, MD

Peter C. Witt, MD

Michael R. Wolfson, MD

### Class of '81

Camilla Ashley, MD

Karen Ledwith Dedman, MD

Neal F. Devitt, MD

Dale H. Foster, MD

### Top Five Classes by Dollars Donated

Rank	Year	Amount
1.	1975	\$ 74,750.00
2.	1915-24	\$ 22,737.90
3.	1987	\$ 13,365.00
4.	1978	\$ 10,639.00
5.	1974	\$ 7,800.00

### Class of '79

Richard D. Belkin, MD

Steven V. L. Brown, MD\*

Timothy Lloyd Burke, MD

Susan Honeycutt Clark, MD

Michael Kane Cochran, MD

Christopher W.

Conavay, MD

James Philip Conterato, MD

Thomas A. Deutsch, MD\*



David W. Hines, MD\*  
 Daniel R. Jarzemyk, MD  
 Linda R. Kaplan, MD  
 Amelia H. Kaymen, MD  
 Steven A. Kooperman, MD  
 Judith A. Kooser, MD  
 Kenneth R. Korzec, MD  
 Thomas E. Liao, MD  
 Sarah T. Lincoln, MD  
 Eric Lyerla, MD  
 Stavros N. Maltezos, MD\*  
 Mark J. Marzano, MD  
 Francine Palma-Long, MD  
 Terrence L. Pencek, MD  
 John R. Peters, MD  
 Jack B. Petrie, MD  
 Kathleen M. Shannon, MD  
 Lisbeth A. Suyehira, MD  
 Fred M. Volkman, MD  
 Jeffrey Wishik, MD

## Class of '82

Stephen F. Bansberg, MD  
 Robert John Barnes, MD  
 Sharyn L. Barney, MD  
 Henry Trent Barnhart, MD  
 Paul R. Blattberg, MD\*  
 Andrew Dale Edwards, MD  
 Michael Feltes, MD  
 Barbara J. Green, MD  
 Mary M. Hagerty, MD  
 H. Eileen Lukk, MD  
 Cynthia R. Morgan, MD  
**Ira M. Nathanson, MD**  
 Paul J. Schmidt, MD  
 Manojkumar Shah, MD  
 Greg E. Sharon, MD  
 Philip J. Van, MD  
 John G. Wahlstrom, MD  
 Keye Luc Wong, MD  
 Daniel Yohanna, MD

## Class of '83

Kevin Conlon, MD  
 Alison J. Drumm, MD  
 Seth L. Gendler, MD  
 Karen Ann Griffin, MD  
 Cynthia Hahn, MD  
 C. Grafford Hilgen-  
 hurst, MD  
**Paul J. Jones, MD\***  
 Gary L. Koehn, MD  
 Lisbeth M. Lazon, MD

Truong Sinh Leduc, MD  
 Mark N. Levin, MD\*  
 Curt E. Liebman, MD  
 George Marosan, MD  
 Stanley P. Maximovich, MD  
 Thomas A. Mayer, MD  
 Anne R. McCall, MD  
 Kathryn H. Mulligan, MD  
 John E. Nelson, MD  
 Bryan P. Pechous, MD  
 Ronald Pepitone, MD  
 Jose R. Quero, MD  
 Scott A. Rubinstein, MD  
 Stephanie Smythe, MD  
 Jonathan R. Starr, MD  
 Ellen Tabor, MD  
 Henry D. Tazelaar, MD  
 Charles Tomaszewski, MD  
 Ashfaq A. Unwala, MD  
**Karen Weinstein, MD\***  
 Lori M. Winer, MD

## Class of '84

David A. Bennett, MD  
 Larry D. Cripe, MD  
**Sharon Thomas Flint, MD**  
 Kathleen L. Geary, MD  
 James S. Gregory, MD  
 Mary K. Haag, MD  
 James A. Hunter, MD  
 Valerie Y. Ito, MD  
 Marilyn J. Jarosky, MD  
 David A. Ladden, MD  
 David L. Lemak, MD  
 Mark Litchman, MD  
 John S. Looper, MD  
 Marian Macsai-Kaplan, MD  
 Timothy R. McCurry, MD  
 Thomas J. Nielsen, MD  
 Crystal Hedgl Peoples, MD  
 Faye R. Rosenbaum, MD  
 Lisa F. Rosenberg, MD  
 Mary Louise Scully, MD  
 Michael A. Skinner, MD  
 Timothy W. Starck, MD  
**Ronald H. Stefani, Jr. MD**

## Class of '85

Richard M. Baley, MD  
 Bradley A. Bertram, MD  
 Jai H. Cho, MD  
 Linda Evans, MD  
 Mark A. Frankle, MD

## Top Ten Classes by % of Participation

Rank	Year	% of Class
1.	1942	50%
2.	1940	37%
3.	1933	36%
4.	1930	33%
5.	1938	31%
6.	1975 & 1941	30%
7.	1978	28%
8.	1932 & 1939	27%
9.	1934 & 1974	26%
10.	1977	25%

Robert Winston  
 Frederick, MD  
 John Grauer, MD  
 Diane Gruber, MD  
 John Joseph Hayes, MD  
 David P. Hejna, MD  
 Bradley L. Hubbard, MD  
 Colman Kraff, MD  
 Nicki E. Lekas, MD  
 Amy Light, MD  
 Charles R. Lindley, MD  
 Shari Ludwig, MD  
 Susan H. McDunn, MD  
 Rosemary McGrath, MD  
**Nina A. Paleologos, MD**  
 Scott B. Palmer, MD  
 Stephen Paul, MD  
 Antoinette G. Quigley, MD  
 Ellen B. Rest, MD  
 Susan Roth, MD  
 Kathryn G. Schutt, MD  
 David Simon, MD  
 Stephen M. Smith, MD  
**Wendy Stock, MD**  
 Rebecca Unger, MD  
 Michael L. Waszak, MD  
 Randall S. Zielinski, MD

## Class of '86

Jeffrey Scott Alberts, MD  
**Susan Anderson-  
 Nelson, MD\***

Lauren Beth Baker, MD  
 Lesley E. Brinkman-  
 Moisman, MD  
 Joseph L. D'Silva, MD  
 Nancy Kathleen Deaton, MD  
 Ann Theresa Farrell, MD  
 Elizabeth A. Frederick, MD  
 Susan L. Haverstock, MD  
 W. Scott Jellish, MD  
 Sanford Lorin Lapin, MD  
 Derek J. Li, MD  
 Mary Jane Milano, MD  
**Timothy Joseph  
 Morton, MD\***  
 Michael Thomas  
 Nathan, MD  
 Ralph H. Newman, MD  
 David Wayne Ozinga, MD  
 John Jay Shannon, MD  
 Stuart Ray Verseman, MD

## Class of '87

Carol Ann Barrette, MD  
 Eric Hubertos Benink, MD  
 Jane Ellen Billeter, MD  
 Jack Victor Carlisle, MD  
 Jonathan Samuel  
 Cohen, MD  
 Christopher J. Dewald, MD  
 Pamela M. Donlan, MD  
 Paul K. Feldman, MD



Mitchell Goldman, MD  
 Cynthia L. Gould, MD  
 Helen R. Minciotti  
 Koehler, MD  
 Kathryn Ann Lemmer-  
 man, MD  
 Frederic Evan Levy, MD  
 Brian Keith Locker, MD  
**Mary Lou Meengs, MD**  
 Raymond L. Pierce, MD  
 Jay Ira Sandlow, MD  
 David John Schleicher, MD  
 David Nathan Schwartz, MD  
 Neil Jay Thomas, MD  
 Gary Edward Waters, MD  
 Susan Wilcoski, MD  
 Steven Clement Yuill, MD

## Class of '88

Anthony Joseph Bell, MD  
 Gregory Edmund Chow, MD  
**Maureen Shea Holland, MD**  
 Louise Berner Holmberg, MD  
 Richard Jay Katz, MD  
 Sravanthi R. Keesara, MD  
 David Ralph Onsager, MD  
 John Francis Sweeney, MD  
 Cynthia M. Waickus, MD  
 Terrie Lynn Weir, MD  
 Nanajan Yakoub, MD

## Class of '89

Melanie Anne Cerinich, MD  
 Chae O. Chu, MD  
 Salvador Gutierrez, MD  
 Ian Jasenof, MD  
 Michael Martirano, MD  
 Mary L. McComis, MD  
 Diane Louise Mueller, MD  
 Paul A. Sauer, MD  
 Maria V. Swastek, MD  
 Elaine Lee Wade, MD  
 Elizabeth Ann Wetzell, MD

## Class of '90

**Christopher L. Coogan, MD**  
 Peter A. Degolia, MD  
 Terrence P. Gleason, MD  
 George Kovacevic, MD  
 Shelia Marie Major, MD  
 Michael Jay Paveloff, MD

Lisa M. Peck, MD  
 Linda M. Razbadouski, MD  
 Marc C. Sandrolini, MD  
 Bruce C. Summerville, MD  
 Lori Siegert Swan, MD  
 David Yeung, MD

## Class of '91

Luther L. Gaston, MD  
 Jerome James Hannigan, MD  
 Kevin Yui Lau, MD  
 Patrick Keung Lau, MD

## Class of '92

Michael C. Cardwell, MD  
 Gonzalo D. Castillo, MD  
 Michael John Costello, MD  
**Roy G. Eenigenburg, MD**  
 Mariann Loffredi, MD  
 Patricia D. Neyman, MD  
 Colleen Jean Reichel, MD

## Class of '93

Gail Gizzo, MD  
 Sunanda V. Kane, MD  
 Fred J. Rothenberger, MD

## Class of '94

Karen Lehew, MD  
 Raymond Nemec, MD  
 Desiree Soter, MD  
 Joan Temmerman, MD  
 Christine Ward, MD

## Class of '95

Marsha Beth Novick, MD  
 Karen Imperio Relucio, MD

## Class of '96

Dianna Marie Bardo, MD  
 Paul Brian Eckburg, MD  
 Andem Esong  
 Ekpenyong, MD  
 James Joseph Fedinec, MD  
 Mark Edward Johnson, MD  
 Karin H. Molander, MD  
 Traci Lynn Pritchard, MD

# Doctoring in a Rural Fast Lane

by Amanda Temple

Settling your family and farm on "Roller Coaster Road," seems to be asking for a life of nonstop activity. While the ride isn't a wild one in the small, rural community of Darlington, Wis., it's one Robert Bernadoni, MD '78, is glad he chose to take after graduating from Rush and specializing in family practice.

"I wouldn't trade places with anyone," says the Distinguished Alumnus Award nominee. "There's something very gratifying about knowing the patients outside of your office. They're your neighbors, your kids play with their kids. They depend on you."

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*"There's something very gratifying about knowing the patients outside of your office."*

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Since Bernadoni's clinic is the only one in the county seat, most of the approximately 2,300 inhabitants of Darlington have had to depend on their neighbor at least once for medical care. Despite a small staff, the clinic isn't limited in terms of service. "From motor vehicle accidents, to warts on the toes to physicals, you name it, we see it," says the family practitioner.

When he's not delivering babies or medical advice, Bernadoni can be found aboard a tractor or another piece of farm machinery performing less precise surgery on his 100-acre farm. When he's feeling really industrious, Bernadoni trades his scrubs for a tool belt and works on his never-ending house renovation. "I've put about 15 years of work in this house," he says, with the mix of pride and pain that every do-it-yourselfer knows. "I've got about another 15 to go."

Despite his lengthy project list, growing practice and affinity for the tractor seat, Bernadoni never runs out of time for his family. "He manages to simultaneously be a father to four kids and almost single-handedly keeps the rural hospital in Darlington alive," said Richard Hogan, MD '78, who nominated his friend. "He just never tires out."

Bernadoni is quick to good-naturedly downplay his friend's praise. He does admit that life on the farm, especially when your wife is the district attorney, isn't any less hectic than life in the fast lane. ■





# Class Notes

On the following pages, Rush Medical College alumni from around the globe share their professional and personal achievements. To let your classmates learn what you've been up to, fill out the "What's New With You?" card inserted into this issue or write: The Alumni Association of Rush Medical College, 1700 Van Buren, Suite 250, Chicago, IL 60612; E-mail: [lfriedma@rush.edu](mailto:lfriedma@rush.edu)

## 1930s

Entering his 65th active year in medicine, **NATHANIEL REICH, MD '32**, of Brooklyn, N.Y., has written a number of books, including a volume of poetry titled *Reflections* and a memoir of his travels and lectures on six continents, called *A Renaissance Man at Large*.

**C. E. MUHLEMAN, MD '37**, of Crown Point, Ind., reports that he misses pediatrics now that he's retired but still manages to stay busy.

**J. DAVID STRATTON, MD '37**, of Charlotte, N.C., retired in 1982 after 33 years in general and ophthalmologic practice. He writes that he is relatively healthy and active and "computerizing now in my old age." He has been married for 58 years and has four children.

**MORRIS S. FRIEDMAN, MD '38**, has recently retired from orthopedic surgery. He lives in South Bend, Ind.

After 50 years of an internal medicine practice, **JAMES W. CHAMBERS, MD '39**, of Des Moines, Iowa has retired and enjoys a quiet life with his wife, Molly, their four sons and their families. His activities include some travel, spending summers at a lake house in northern Iowa, and occasional work for a U.S. military induction station.

## 1940s

**C. M. GRACE, MD '41**, of Edmonds, Wash., writes: "I didn't know what a full life Rush was going to introduce me to upon graduation in 1941. I met my wife 56 years ago at the 'Y'; then the Navy called me overseas with the Marines; then it was private practice for 13 years; then government service again within the U.S.; then overseas to West Africa and Southeast Asia. What an abundance of fascinating and exotic diseases and experiences. I'm now happily retired in a beautiful part of our land."

**JOSEPH L. PACE, MD '42**, of Salt Lake City writes: "We've spent a good deal of this past year rewriting our trust and our wills, and beginning the very traumatic task of setting up a limited liability corporation to begin giving some of our assets to our children now; we're also trying to set our estate in good stead."

## 1970s

After serving as the secretary and treasurer of Illinois Masonic Medical Center's 900-member medical staff, **CURTIS WHISLER, MD '74**, has been elected vice president of the medical staff. Whisler joined Illinois Masonic, in Chicago, Ill., in 1979 after completing his residency in orthopedics at Rush.

**PAULA JAODES, MD '75**, was appointed president and chief executive officer of La Rabida Children's Hospital in Chicago.

**JOSEPH E. KELLEY, MD '77**, was recently promoted to Brigadier General. Commander of the medical center at Wright-Patterson Air Force Base in Ohio, he directs one of the Air Force's largest medical centers. He is also the lead agent for the Department of Defense Health Service Region 5, responsible for coordinating military



Robert Kirkman, MD '42 (left) talks with Harold Laufman, MD '37. While they graduated a few years apart, Kirkman and Laufman found they have a lot in common, including playing the violin.



medical services that serve a population of 675,000 in a seven-state region. Kelley has served the Air Force as a flight surgeon, general surgeon and medical manager. His decorations include the Legion of Merit, the Meritorious Service Medal with three oak leaf clusters, the Air Force Commendation Medal, and the Air Force achievement medal with one oak leaf cluster. He and his wife, Sharon Joy, have two children, Tim and Jessica.

**DAVID STAIR, MD '77**, an internist in Wallingford, Conn., has been inducted into the American College of Physicians. Stair holds a master's in philosophy from Yale University and completed his internship and residency in general and orthopedic surgery at the University of California-San Francisco.

**SHANNON J. SCARRY, MD '78**, recently joined Friends Hospital, a psychiatric care facility in Philadelphia, as medical director of its admissions and evaluation service.

**PAUL C. FOX, MD '79**, has joined the associate staff of Frick Hospital and Community Health Center in Melcroft, Pa., with privileges in family practice and pediatrics.

**KENNETH KUZNETSKY, MD '79**, recently was appointed to the medical staff at Resurrection Medical Center in Niles, Ill. He also completed his internship, residency and fellowship at Rush. He specializes in nephrology.

**THOMAS ZOELLER, MD '79**, is a practicing reconstructive and plastic surgeon in Ocala, Fla., and specializes in rebuilding damaged body parts.

## 1980s

**BETH PLETCHER, MD '82**, is keeping busy in Chester, N.J., where she teaches and practices genetics at UMDNJ-NJMS. Fun at home includes

keeping up with 2-year-old Brittany and doing science projects and karate with 7-year-old Brett.

**CHRISTINE DARR, MD '83**, and **GLENN SAKAMOTO, MD '83**, of Englewood, Colo., write that they have three children, Derek, Claire and Devin. Darr is chairman of pediatrics at Columbia Rose Medical Center and practices pediatric emergency medicine. Sakamoto is in private practice as a colorectal surgeon.

**MARK CAMERON DAVIS, MD '83**, reports that he is married to Ann Tran, MD, a fellow radiologist in private practice in Baltimore, and that they have three children: Michael, Christopher and Laura. He is employed currently as the medical director of Med-Tel International in McLean, Va., a teleradiology company with imaging centers in Maryland and Ohio.

**EDWARD G. SHAW, MD '83**, is professor and chairman of the Department of Radiation Oncology at the Bowman Gray School of Medicine, and associate director for clinical research at the Comprehensive Cancer Center of Wake Forest University in Winston-Salem, N.C. He and his wife, Rebecca, have three daughters.

**SONDRA SUMMERS, MD '83**, and **DANNY SUGIMOTO, MD '83**, live in Oak Park, Ill., with their three sons Mike, Eric and Dan. Summers has moved her obstetrics and gynecology practice to Loyola University, and Sugimoto recently has opened Cedar-Crosse Research Center in addition to seeing patients at his regular practice in internal medicine.

After moving back to Chicago last year with his wife, Cindy, and three daughters, **STEPHEN ONDRA, MD '84**, joined the faculty at Northwestern University and specializes in spinal reconstructive surgery. He also serves as the assistant program director in neurosurgery.

**GUY J. PETRUZZELLI, MD '87**, has been named a fellow in the American College of Physicians. He currently holds a faculty position at Loyola University Medical Center in Maywood, Ill., as well as memberships in the American Society for Head and Neck Surgery, the Society for University Otolaryngologists and the American Cancer Society.

**MARK DWORKIN, MD '89**, is working for the Centers for Disease Control and Prevention in Atlanta, Ga., in the Division of HIV/AIDS Prevention. He also works part time in an infectious diseases private practice.

**STEVEN C. HENRICKS, MD '89**, has been appointed to the Columbia Portsmouth Regional Hospital and Pavilion in Portsmouth, N.H. Columbia Portsmouth Pavilion is a 65-bed psychiatric hospital serving adults and adolescents, and offers an Intensive Outpatient Program for patients coping with alcohol or drug dependency.

After finishing his chief residency in general surgery at the Mayo Clinic, **HYUN KIM II, MD '89**, has joined Crawford Memorial Hospital and Healthcare Services in Oblong, Ill. He and his wife, Peggy, have two daughters, Elizabeth and Emily, and report that the family enjoys tennis, fishing and hiking.

## CORRECTION

*Rush MD* apologizes for an error printed in the Spring/Summer 1997 issue. A corrected version is as follows:

**BARBARA GREEN, MD '82**, is practicing neurology in St. Louis. Green is active locally and nationally with the Multiple Sclerosis Society. She and her husband, David, have four daughters: Rebecca, Emily, Abby and Jocelyn.



The YWCA of Jamestown, N.Y., recently honored **DIANE MUELLER, MD '89**, as one of its first "Women of Achievement in Chautauqua County" awards. Mueller — who developed and now heads the Department of Family Practice at WCA Hospital and teaches family medicine at the University of Buffalo — was presented with an award for entrepreneurship.

## 1990s

**OSAMA ATIEH, MD '90**, has joined the ambulatory services of the Internal Medicine Center of Christ Hospital and Medical Center in Palos Heights, Ill. A diplomat of the American Board of Internal Medicine and the National Board of Medical Examiners, Atieh is a member of the American College of Physicians and the American Medical Association. He also serves as an instructor for medical residents at Christ Hospital in the ambulatory care clinic.

**ANDREW BOSHARDY, MD '90** — along with his wife, Pat, and two sons, Drew and Kyle — has left city life for rural Pittsfield, Ill., where he is on staff at the Quincy Medical Group.

**GREGORY W. JOHNSON, MD '90**, has been serving as the Chief of Family Practice at the Air Force Clinic on the NATO base near Geilenbirchen, Germany.

Part of a two-physician primary-care practice in the Hudson Valley area of New York, **CHARLES KUCERA, MD '90**, writes that his areas of interest include HIV/AIDS and hospice medicine.

**JAMES J. LEE, MD '90**, writes that he has recently returned to Chicago after finishing his military obligation in Washington D.C. He passed the boards for otolaryngology and joined Elmhurst Clinic.

**PATRICIA LOOFBOUROW, MD '90**, reports that after two years in private practice in Upland, Calif., she is now a part-time faculty member at San Bernardino County Medical Center's Family Practice residency. She has three children: Rebekah, Gerard and Corwin.

**ANTHONY NAZAROFF, MD '90**, is working at a solo urology practice in Gainesville, Ga.. He and his wife, Anne, have a daughter named Sonia.

Along with his family — wife Lynette Rosati and daughters Anne, Catherine and Sarah — **DAVID SHIM, MD '90**, relocated to Cincinnati, Ohio in 1996. He is a professor of pediatric cardiology at Cincinnati Childrens' Hospital Medical Center. He has specialized in interventional cardiac catheterization.

**CHIMENE ROBBINS-PELLAR, MD '91**, is currently in private practice working out of Evanston Hospital in Obstetrics and Gynecology. She and husband Michael welcomed a baby boy, Nicholas, on April 28, 1997.

**EL-ROY DIXON, MD '91**, writes that he is the medical director at the Albany Medical Eye Center and has been board certified by the American Academy of Ophthalmology. He and his wife, Sheron, have a son, Rondolph, and a daughter, Anastacia, and live in Albany, Ga.



**Tanmeet K. Seth, MD '97 (right) and friend at this year's commencement banquet.**

**JAMES A. GRAMM, MD '91**, has completed a residency in general surgery and recently began a fellowship in cardiovascular surgery at Loyola University Medical Center. He lives in Naperville, Ill., with wife Cynthia and son James Jr.

**ANNE MARIE KUDELKA, MD '91**, has joined North Shore Cardiology Consultants in Evanston.

**GEORGE I. SRECKOVIC, MD '91**, is in private practice on the staff of Palos Community Hospital and St. Francis Hospital. He lives in Chicago.

**JOHN MIGAS, MD '92**, has joined the staff of Mid Illinois Hematology and Oncology Associates in Normal, Ill. Migas is currently completing his oncology fellowship at the University of Iowa in Iowa City, and will be moving to Bloomington/Normal upon completion.



**AL RANDY DOYLE, MD '93**, is pleased to announce the birth of his son, Gerhard Benjamin Doyle, on March 13, 1997. He recently relocated to the Quad Cities area of Illinois to pursue a practice in psychiatry.

**LILLIAN FOCA-MUNOZ, MD '93**, has joined the staff of Personal Physicians in Cicero, Ill., as a new partner. Foca-Munoz, an honors student in medicine, preclinical behavioral science, endocrinology and family practice clinical programs, has also been designated a member of Chicago's Leaders of Today and Tomorrow by the city of Chicago.

**JULIE A. GELMAN, MD '93**, works at Osler Medical Center in Melbourne, Fla., where she treats patients suffering from obesity through a combination of medications, diet and exercise, and lifestyle counseling. Gelman completed her residency in internal medicine at Lutheran General Hospital in Park Ridge, Ill.

**JENNIFER PLOTKIN, MD '93**, has been appointed to Resurrection Medical Center in Morton Grove, Ill. She recently completed her residency at the University of Illinois Chicago Medical Center and is a member of the American College of Emergency Physicians and the American Academy of Emergency Medicine.

**BLAIR M. ROWITZ, MD '93** is working out of Allegheny Medical in Pittsburgh. At last report, he and wife Joyce were expecting a new baby.

The first pediatrician practicing in Princeton, Ill., in many years, **SUSAN BARDWELL, MD '94**, was a NIH Research Scholar at the Howard Hughes Medical Institute in Bethesda, Md., where she conducted extensive research in allergic diseases. She also received the Upjohn

Achievement Award in 1994 for her research in allergies.

After completing two years of Internal Medicine at Stanford University Hospital, **ANDREW C. McNEIL, MD '94**, has "short-tracked" into infectious diseases at the National Institutes of Allergy and Infectious Diseases in Bethesda, Md.

**ANN MIRCHEVICH, MD '94**, has just married Jon G. O'Connor and is a pediatric surgery research fellow in Seattle, Wash.

**TOM NELSON, MD '95**, reports that he is serving as a medical officer on the USS Juneau in San Diego, and he and wife Beth welcomed a baby girl, Leslie Elizabeth, into the family on December 26, 1996.

**MARSHA NOVICK, MD '95**, recently completed a one-month tropical medicine rotation in Swaziland and is completing her second year of her family-practice residency at the University of Pittsburgh, St. Margaret Hospital.

## Pioneering Pediatrician Remembers 60 Years in Medicine

by Rebecca Trissler

In 1937, the Depression was still in full swing. No one had heard yet of the atomic bomb, much less heart transplants or the Internet.

That year, a young doctor named H. Sidney Heersma, MD '35, left his residency at Rush and the bustle of Chicago for Kalamazoo, Mich., to begin the area's first pediatric practice. The Oak Lawn native had heard from a local obstetrician that Kalamazoo was in dire need of a pediatrician.

It was just the chance he'd been looking for all his life. "I decided to be a doctor at six years old," Dr. Heersma says. "My mother had revered her family doctor. We were farm people, so I was kind of pioneering in that respect."

Heersma says his practice was, at first, typical of the age — he saw cases of rheumatic fever, polio, and other diseases now wiped out by penicillin and vaccinations. Then in the 1940s, Heersma helped the Michigan Department of Health start the first outpatient clinics; his own specialized in treating children with rheumatic fever and congenital heart disease. "It's hard to believe that at that time there were no outpatient clinics in hospitals, that hospitals only saw inpatients," he says.

Last year, Heersma was awarded the Earl Wright Community Achievement Award for his role in establishing his clinic. "Fortunately I've been in a position to practice the way I feel it should be done, doing good for people who can't get it done otherwise," says Dr. Heersma.

At 88, Heersma still sees patients three mornings a week at the Michigan State University Kalamazoo Center for Medical Studies Major Disease Clinic. But he leaves room in his schedule for fishing, bridge, and spending time with his family. He and his wife, Ellen, are the parents of two and the grandparents of four. They were recently blessed with a new great-grandchild as well.

As for retirement, Heersma says that he'll see how he feels this December 1 — his 60th anniversary of practicing in Kalamazoo — and take it from there. "Depends on how I still like it," he says.



# In Memoriam

## 1920s

**CLIFFORD H. HARVILLE, MD '25**, of Warsaw, N.Y., March 6, 1997.

**JULIAN M. BRUNER, MD '27**, of Des Moines, Iowa, June 20, 1997.

## 1930s

**JACK SLOAN, MD '31**, of Chicago, Jan. 10, 1995.

**WILLIAM S. KITT, MD '32**, of Tucson, Ariz., June 22, 1996.

**CLINTON S. M. KOERNER, MD '33**, of Peoria, Ill., July 1, 1996.

**MILTON M. KARDON, MD '34**, of Naples, Fla., Feb. 29, 1996.

**CHARLES WYLIE, MD '34**, of Camarillo, Calif., Jan. 19, 1997.

**MYRON F. SESIT, MD '35**, of New York, April 25, 1997.

**HAROLD J. BRUMM, MD '36**, of Menlo Park, Calif., Jan. 18, 1997.

**LEO MARKIN, MD '36**, of Lincolnwood, Ill., Oct. 25, 1996.

**WILFRED LORCH OLSEN, MD '36**, of Polson, Mont., Sept. 28, 1996.

**OLIVER HOWE LOWRY, MD '37**, of St. Louis, June 29, 1996.

**RICHARD D. PETTIT, MD '37**, of Altadena, Calif., May 14, 1996.

**CARL ANTHONY WALVOORD, MD '37**, of South Holland, Ill., April 2, 1996.

**BERNARD M. KRAMER, MD '38**, of Woodbridge, N.J., April 25, 1997.

**CHARLES EDGAR MAGNER, MD '38**, of Great Falls, Mont., May 19, 1996.

**RODGER B. SMITH, MD '38**, of Mason City, Iowa, Nov. 8, 1996.

**GORDON R. BROWN, MD '39**, of Winnetka, Ill., Oct. 6, 1996.

**LOUIS S. PERRY, MD '39**, of Ogden, Utah, July 9, 1996.

## 1940s

**E. GORDON BEHRENTS, MD '40**, of Galesburg, Ill., August 31, 1997.

**VIRGINIA M. FERRARA, MD '40**, of Birmingham, Mich., Feb. 10, 1996.

**RALPH SILER MORGAN, MD '41**, of Webster, N.C., Nov. 6, 1996.

**NORMAN TAUB, MD '41**, of Georgetown, Del., Jan. 2, 1997.

**WILLIAM F. BETHARD, MD '42**, of La Jolla, Calif., Jan. 13, 1997.

### SAMUEL G. TAYLOR MD '32,

a pioneer in the field of cancer treatment, died on May 10, 1997, at the age of 92. He had lived in Lake Forest, Ill.



Dr. Taylor is credited with helping establish the field of medical oncology in the United States. In 1954, he was appointed director of the Section of Medical Oncology of Presbyterian-St. Luke's Hospital, the first program of its kind in the nation.

Dr. Taylor championed the role of the internist, over the surgeon, in the care of cancer patients. This concept, unique in its time, gave cancer patients options in seeking treatment.

Dr. Taylor graduated from Yale University. He was on the faculty of the University of Illinois College of Medicine from 1943 to 1972 and became a professor of medicine at Rush Medical College in 1971.

In 1973, the American Cancer Society presented Dr. Taylor with its

annual award for Distinguished Service in Cancer Control.

In 1974, Rush established the Samuel G. Taylor III Endowed Chair in Medical Oncology in his honor. Subsequently, Rush awarded Dr. Taylor with two of its highest honors, the Trustee Medal and the Distinguished Alumnus Award, in recognition of the distinction he has brought to the institution.

Survivors include his wife, Jocelyn; a daughter; two sons; two stepdaughters; and three great-grandchildren.

### IRENE TURNER,

assistant professor at Rush Medical College, died June 19, 1997, of pancreatic cancer. She was 76.



The daughter of Russian immigrants, Ms. Turner moved from Lithuania when she was two years old. In the 1950s, she broke into the healthcare field with a medical technical degree, and eventually became one of the city's most respected

health demographers and researchers.

Soon after joining the staff at Rush, she helped prepare a report that was influential in convincing the Illinois State Legislature to provide aid for public and private medical schools, including Rush Medical College. Ms. Turner also played a significant role in increasing the number of women and minority students admitted to Rush.

"She had insight into the human condition that helped us all become better physicians," says Henry Danko, MD '76, an associate professor at Rush, and a former student of Ms. Turner's.

In 1982, Ms. Turner received the Clarence Darrow Award for her lifetime commitment to civil rights. This year, in recognition of her loyalty and support to Rush Medical College, Ms. Turner was awarded the James A. Campbell, MD, Alumni Service Award.

Ms. Turner's family has established a scholarship fund at Rush University for minority students. Memorials to the fund can be sent to Rush Alumni Office, 1700 W. Van Buren St., Suite 250, Chicago, IL 60612.



# Alumni Calendar

## Rush MD

Rush MD is published twice a year by the Alumni Association of Rush Medical College, and is produced by the Office of Philanthropy and Communication at Rush-Presbyterian-St. Luke's Medical Center.

Please send your comments or suggestions regarding the magazine to the editor at 1700 W. Van Buren, Ste. 250, Chicago, IL 60612; (312) 942-6976; e-mail: mkennedy@rush.edu

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Sheila Bettison  
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Lynn Friedman  
Assistant Director

### Regular Meetings and Events

#### Obstetrics and Gynecology Grand Rounds

Sponsor: Rush's Department of Obstetrics and Gynecology

Speakers: Various lecturers

Date & Time: Every Thursday at 8 a.m.

Location: Rush-Presbyterian-St. Luke's Campus, 720 Pavilion Conference Room

Contact: Yvonne Allen-Stewart at (312) 942-6613

### Special Lectures, Meetings and Other Events

#### Controversies in Cardiac Surgery

Sponsor: Rush Department of Cardiovascular-Thoracic Surgery

Speakers: Various speakers

Date: December 13, 1997

Location: Rush-Presbyterian-St. Luke's Campus, Searle Conference Center

Contact: Cynthia Adams at (312) 942-6370

#### 19th Annual Neurology for the Non-Neurologist Conference

Sponsor: Rush Department of Neurological Sciences

Dates: December 10-12

Speakers: Various speakers will review current principles in the management of neurologic conditions encountered by the non-neurologist practitioner.

Location: Westin River North Hotel, 320 N. Dearborn, Chicago

Contact: Judy Robins, Education Coordinator, Department of Neurological Sciences. Phone: (312) 942-4540;

Fax: (312) 942-2380;

E-mail: jrobins@neuro.rush.edu

#### 23rd Annual Resident and Fellow Research Day

Sponsor: Rush Department of Obstetrics and Gynecology

Date & Time: April 23, 1998, beginning at 9 a.m.

Speakers: Joanna M. Cain, MD, Professor and Chair, Department of Obstetrics and Gynecology, Pennsylvania State University, Milton S. Hershey Medical Center, Hershey, Pa

Location: Rush-Presbyterian-St. Luke's Campus, Searle Conference Center

Contact: Sharon Mitchell or Yvonne Allen-Stewart at (312) 942-6613

#### The Eleventh Annual Rush Alzheimer's Disease Center Conference

Sponsor: Rush Alzheimer's Disease Center

Date & Time: May 19, 1998, from 8:45 a.m. to 4:45 p.m.

Speaker: Stephen Post, PhD, Case Western Reserve University, Cleveland, Ohio

Location: Inter-Continental Hotel, 505 N. Michigan Avenue, Chicago

Contact: Claire Altschuler at (312) 942-4232

Fee: \$65, including lunch

#### Rush Surgical Society Annual Meeting, with the 12th Annual Frederic A. de Peyster, MD, Rush Alumnus Lecture

Sponsor: Rush Dept. of Surgical Sciences

Date & Time: June 13, 1998, from 7:30 a.m. to 12 p.m.

Speaker: A. Michael Sadove, MD, Professor of Surgery (Plastics), Indiana University School of Medicine, Ind.

Location: Rush-Presbyterian-St. Luke's Campus, Searle Conference Center, Room 542

Contact: Eileen Pehanich (312) 942-6519

## Alumni Weekend 1998

Save the Date June 11-13, 1998

Special reunion activities for the classes of 1938, 1973, 1978, 1983, 1988 and 1993

Watch your mail for more information



# Dreaming Therapy

■ by Amanda Temple

Rosalind Cartwright, PhD, has two words for anyone who thinks bad dreams can't be a good thing:

*Keep dreaming.*

Sleeping through even the nastiest of dreams is better than waking up, interrupting your body's natural nightly rhythm and cutting short the physical and mental restoration sleep provides, says Cartwright, director of the Rush Sleep Disorder Service. Just as important, dreaming may prove to be one of the best self-help therapies, allowing you come to terms with mishaps and tragedies that occur during the day, she says.

"Dreams allow us to do our emotional homework and face our problems when we're in a completely relaxed state," says Cartwright, who also chairs Rush's Department of Psychology. "If we do our homework right, we wake up feeling more energized and better than we did when we went to sleep."

## Researching the Benefits of Dreams

Cartwright is testing the benefits of dreams by studying people who might profit from some nocturnal therapy: those who suffer from depression. In a study funded by the National Institutes of Health, she is studying the sleep patterns of 32 men and women who are going through divorces and are clinically depressed as a result of the breakup.

From an earlier sleep study on 70 unhappy divorced people, Cartwright found that the physiological patterns of dreams reflect subjects' distress levels. Subjects spent three nights in Cartwright's sleep lab attached to electronic monitors that allowed technicians to follow their sleep patterns on a computer screen. After each dream period, subjects were awakened and asked to report the content of their dreams.

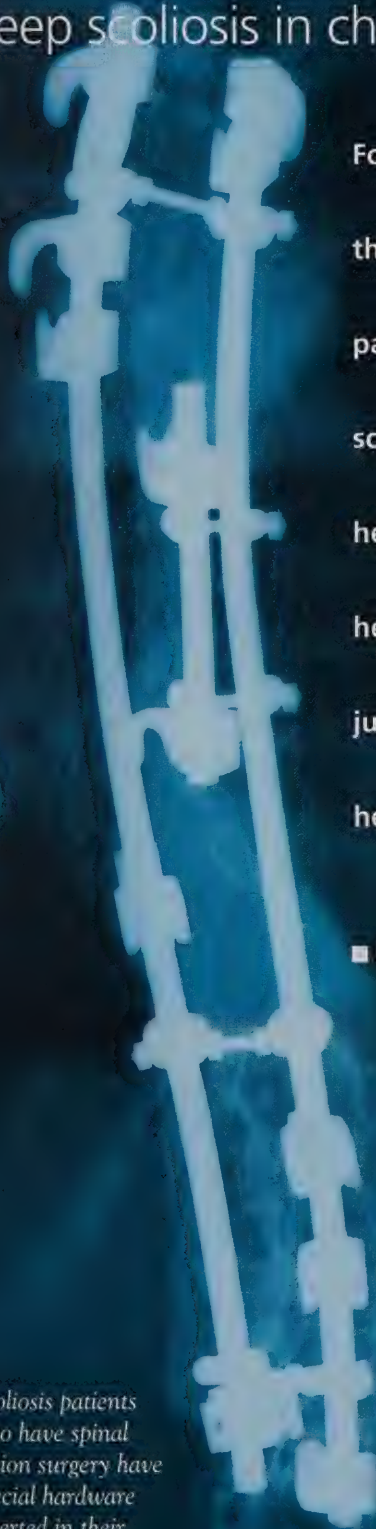






# Ahead of the Curve

Braces and surgery help keep scoliosis in check



For Erica Dziobas,  
the most important  
part of her elementary  
school uniform wasn't  
her dress shoes or  
her blue plaid  
jumper — it was  
her back brace.

■ by Laura Ramos

Scoliosis patients who have spinal fusion surgery have special hardware inserted in their spines to straighten curvatures.

When Erica was a kindergartner seven years ago, a school nurse discovered the young girl had scoliosis, a lateral curvature of the spine. When she was fitted with her first brace in 1990, she says, "It was like I was locked inside something."

For the next six years, Erica started dressing for school by slipping into a tight-fitting T-shirt or body stocking that she'd wear under her brace to avoid irritating her skin. Then she would put on an oversized shirt and jumper that were large enough to fit over the brace. At school, Erica's peers noticed she was different. "Everyone said I had to wear a piece of plastic," she says. "They must have thought I was an alien."

But today, a back brace isn't part of 14-year-old Erica's eighth-grade ward-



Scoliosis patient Erica Dziobas

Photo: Jan Clough



robe. Last year, her X-rays showed that her back was, for the time being, not getting any worse. Now she only has to wear her brace 10 hours at night, down from 23 hours a day. Like other people with scoliosis, Erica will always have a curvature, but her family hopes it won't progress. "We're just playing the waiting game," says Susan Dziobas, Erica's mother.

## Diagnosing the Disease

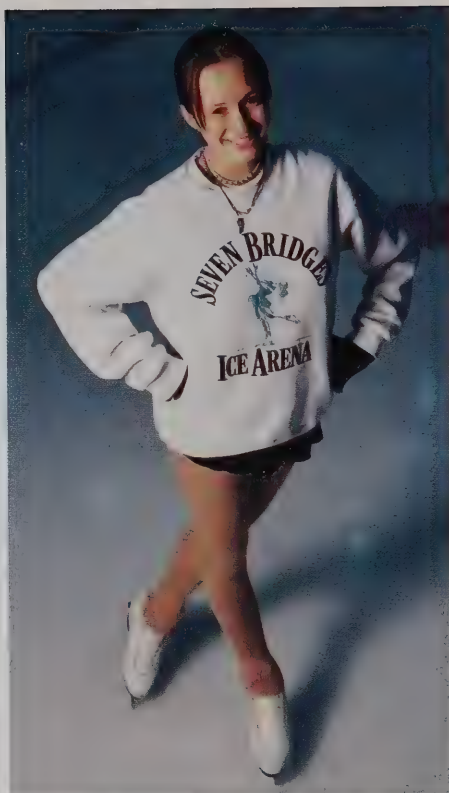
In most cases, the cause of scoliosis like Erica's is unclear, although heredity seems to be a factor. Researchers have not found a way to prevent scoliosis, which targets one in 10 adults and children. If scoliosis is not treated, patients may develop severe back humps or other deformities, back pain, reduced lung capacity, arthritis, poor flexibility and, in rare cases, heart problems. More than 20 states — not Illinois — require schools to check elementary and junior high students for humps and unevenness on their backs that can mean a child has scoliosis.

"The types of scoliosis we're seeing today are much milder than the cases we saw 20 or 30 years ago because they are being recognized so early," says Ronald L. DeWald, MD, director of Rush's Section of Spinal Surgery and an internationally recognized expert in scoliosis.

Parents can tell if a child has scoliosis by checking to see if he or she appears to slump or lean to one side. They may also have humps on their backs because, as the spine curves, it often pushes the ribs out. Children's hips also may be uneven, which causes their pants or skirts to hang unevenly.

Erica has a right thoracic curve, which means her spine resembles an inverted letter "C" when viewed from the back. Other patients have double curves that give their spines an "S" shape. Doctors measure the severity of these curves by degrees using a patient's X-rays. If a curvature is less than 20 degrees, a patient may only have to do special exercises to strengthen the back. If the curve is between 20 and 40 degrees, like Erica's, children and teens usually have to wear a plastic brace. For patients with curves beyond 40 degrees, surgery is usually the best option.

"If you screen 2,000 children, 100 of them will have a curve greater than 10 degrees. One of these children may need surgery," DeWald says.



*Rush patient Jennifer Kec is back on the ice after spinal fusion surgery.*

## Teenage Cooperation

Despite the importance of wearing a brace, getting a child or teenager to do so is not always easy. "Body image is a tremendous thing in this age group," says Mary Faut Rodts, an orthopedic nurse who works with DeWald. "If they are having problems with the brace, we talk with them about it rather than risk having them toss the brace in a closet."

DeWald and his staff also create realistic treatment plans for patients. "If a child comes to us extremely emotionally distraught, we tend not to entertain the idea of brace treatment. A parent can't make a child wear a brace," Rodts says.

When a child cannot tolerate a brace, spinal fusion surgery may be the best option. This surgery is also considered when a patient's scoliosis progresses even with a brace, or if the curve is too severe for bracing.

That was the case for Jennifer Kec, 15, a competitive ice skater whose career was interrupted for a year after her spinal fusion surgery. She had worn a brace for a year when she was 10, but then stopped wearing it out of frustration. Meanwhile, Jennifer's scoliosis progressed rapidly. When Jennifer and her family went to see DeWald last year, he recommended correcting her scoliosis by surgically straightening and fusing her vertebrae.

## An Option for Some: Surgery

Spinal fusion surgery works because bone is a living organ, like skin, that will heal and grow together. But spinal fusion surgery is no easy solution. It carries the risk, as all surgeries of the spine do, that the spinal cord may be affected. But for many patients like Jennifer, it is the only option.

"I was happy to get surgery because I would look better," Jennifer says. "I also had a tough time breathing because my lungs were getting compressed. I was totally off balance when I skated, and I fell a lot." Jennifer, who first started skating when she was 8, had been training for a regional competition in the summer of 1996, but had to drop out because of her surgery. That was hard for Jennifer, whose life revolved around her sport. "I'd go to school, go

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**"The types of scoliosis we're seeing today are much milder than the cases we saw 20 or 30 years ago because they are being recognized so early."**

Photo: Andrew Campbell



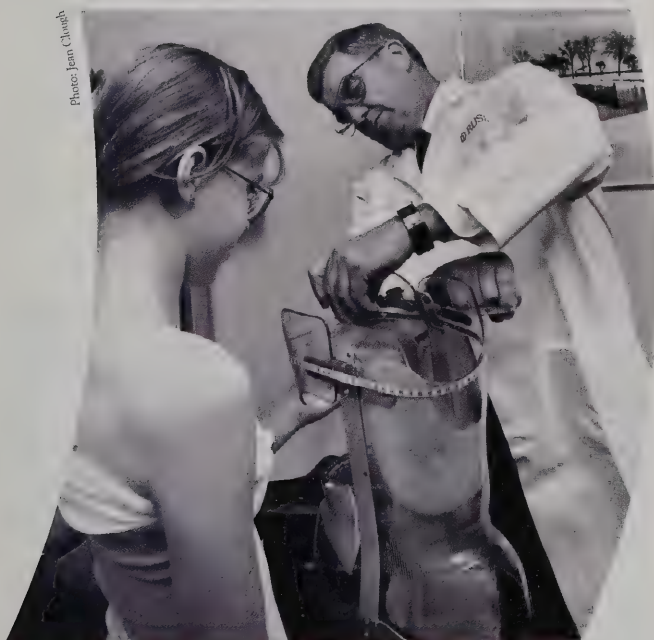
skating and then go to bed."

During Jennifer's surgery, DeWald inserted specially designed hardware through her vertebrae to straighten out her spine. Then he placed bone chips from Jennifer's ribs over her spine so 13 of her vertebrae would fuse into one bone.

When Jennifer woke up from her surgery, she says she felt as if her back weighed 1,000 pounds. She spent 10 days in the hospital and came home two and a half inches taller after her spine was straightened. Amazingly, just four weeks after her surgery, she started her freshman year at high school.

Most children and teens don't have to wear braces after surgery, but Jennifer did because her surgery was so involved. Even though she attended high school in a brace for six months, she actually liked wearing this one. "I felt so much safer. It held me together."

In July, Jennifer went back on the ice for the first time since her surgery last year. DeWald advises her not to try any skating jumps for another year, so she is concentrating on mastering the low-impact moves of ice dancing. Jennifer says she wants to put the surgery behind her and concentrate on what she missed over the last 12 months. "I've got to get the feel of the ice back," she says. ■



Ronald L. DeWald, MD, checks Erica Dziobas' brace every six months.

## Not Just a Child's Disease

Not all scoliosis patients are children and teens. Of the 250 scoliosis patients who will have operations at Rush this year, half are adults.

Some of these patients suffer from degenerative scoliosis, which develops in adults over 40. With degenerative scoliosis, the discs in the spine begin to deteriorate and cause the spinal column to curve and rotate, which may cause terrible back pain, says Christopher J. DeWald, MD, an orthopedic surgeon who works with his father, Ronald, at Rush.

However, most adult scoliosis patients are those who had mild to moderate scoliosis as adolescents or who experience back pain as a result of undiagnosed scoliosis they may have had for decades. As these patients age, their scoliosis may become progressively worse. If this is the case, surgery is the best option. Bracing is ineffective in adults, whose bodies have already matured and whose scoliosis



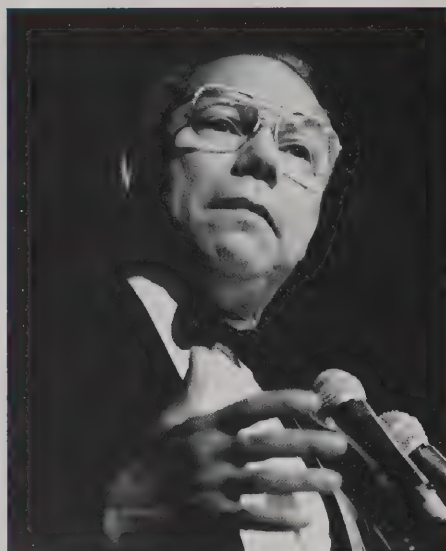
Jean Peters and her husband, Richard, at work.

cannot be kept from progressing with a brace. Unfortunately, doctors usually cannot correct an adult's scoliosis as effectively as a child's because the spine becomes more rigid with age.

Jean Peters, 59, has had two spinal fusion surgeries over the last 16 years to increase her lung capacity and alleviate the pain she experienced from her scoliosis as well as an injury from a car accident. "Now I'm fused from top to bottom," says Peters. Since her last surgery in 1993, she has been able to enjoy something that most people take for granted: sitting. "Sitting was the worst thing I could do for my back. It caused me so much pain," Peters says. "Now I can sit at my desk almost all day long."

Since her surgery, Peters has been able to manage her own food service company from her desk without worrying about the pain. Peters is also surprisingly mobile and more active than ever: She can take hour-long power-walks, which she never would have been able to do before the surgeries.





Gen. Colin L. Powell spoke at the wrap-up celebration for Rush's five-year fund-raising campaign.

## CAMPAIGN FOR RUSH RAISES \$222 MILLION

On May 29, more than 750 Rush donors and community leaders gathered in the Grand Ballroom of the Chicago Hilton and Towers to celebrate the close of the Medical Center's successful five-year fund-raising campaign.

"When we started out five years ago, our goal was to raise \$160 million in private philanthropy to support the people and programs that have made Rush one of the finest medical centers in the Midwest and in the country," said Edgar D. Jannotta, who chaired the campaign.

"We now stand at \$222 million, with all of our major priorities met. That's just a fantastic accomplishment," said Jannotta, who is senior director at William Blair & Company, L.L.C., and a longtime Rush trustee.

Guests at the black-tie gala included Chicago Mayor Richard M. Daley. In his speech, Daley praised Rush's community service work on the city's West Side.

Gen. Colin L. Powell, the keynote speaker, was also impressed by Rush's fund-raising effort. "Corporations, government, individual citizens, volunteers, doctors and staff have come together to make this campaign such a success and, in a period of just five years, have pulled together almost a quarter of a billion dollars," said Powell, in his speech. "It shows what you can do when you believe in something, and when you're willing to give of your time, talent and treasure to benefit your fellow citizens."

## RUSH AND COOK COUNTY HOSPITAL UNITE AGAINST AIDS WITH NEW TREATMENT FACILITY

Thanks to new drug treatments and prevention strategies, the number of people dying from AIDS is on the decrease for the first time. But the disease has not gone away. Thousands of Chicagoans infected with the human immunodeficiency virus still require complicated treatment and frequent hospitalizations. In response, Rush and Cook County Hospital recently began construction of the CORE Center.

Opening in the fall of 1998, this 60,000-square-foot, \$25-million facility will specialize in the care of HIV-positive patients. The center will also promote AIDS prevention and support research on AIDS and other infectious diseases.

More than 300 community leaders, healthcare professionals and donors attended a ground-breaking ceremony for the CORE Center on June 11. The keynote speaker was Donna E. Shalala, PhD, secretary of the U.S. Department of Health and Human Services.

"Today we not only break ground, but we gain ground," said Shalala. "We break ground around a facility that will care for all of the complex needs of people living with HIV. We gain ground by building a seamless system of integrated public and private services so that no one falls between the cracks."

The CORE Center represents the first time public and private sectors have joined forces for such a health-related endeavor. "This unique partnership will ensure the best and most accessible care in the complex care of patients with HIV/AIDS, as well as create a national model for the prevention, treatment and research relevant to this epidemic," said Ruth M. Rothstein, chief of the Cook County Bureau of Health Services and director of Cook County Hospital.

Collectively, Rush and County treat approximately 25 percent of people infected with HIV in the Chicago metropolitan area. But both hospitals lack the space, proper physical conditions and equipment to deliver adequate treatment to these people.

Nearly five years ago, infectious disease physicians from Cook County Hospital and Rush recognized the need to combine their resources to fight this deadly disease and developed the concept of the CORE Center.

"They saw that they could provide a higher quality of care from a specialized facility and that it would be less costly because it could reduce inpatient hospitalizations," said Leo M. Henikoff, MD, president and chief executive officer at Rush.

The CORE Center will be located at the northwest corner of Harrison Street and Damen Avenue. To be operated by the Cook County Bureau of Health Services with medical services supplemented by Rush, the CORE Center will provide comprehensive health care and related social services to those already living with HIV and to those at risk.



Chicago Mayor Richard M. Daley (far right) was among the dignitaries who broke ground for the CORE Center.



## RUTH E. SCHMIDT, RN, 1912-1997



Ruth E. Schmidt, RN

Ruth E. Schmidt, a registered nurse and devoted friend of Rush, died on Sept. 29. She was 85.

Born in Huron, Ohio, Miss Schmidt graduated from Presbyterian Hospital School of Nursing in 1934. She began her career as a nurse in Presbyterian Hospital's operating room and went into private duty nursing in the early 1940s. During World War II, she worked for the FBI as a nurse-companion to the

mother of a captured spy, accompanying the woman during the spy's trial and conviction in Washington, D.C. She returned to Presbyterian's operating room after the war, and continued to work as director of operating-room nursing through the merger of Presbyterian with St. Luke's Hospital and the 1969 formation of Rush-Presbyterian-St. Luke's Medical Center.

Miss Schmidt, who retired from Rush in 1974, lived for more than 50 years at the Allerton Hotel in Chicago. For the

past four years, she lived in the Johnston R. Bowman residential apartments on the Rush campus.

Miss Schmidt was an active member of the Nurses Alumni Association. A philanthropic supporter of Rush, she was a member of the Golden Lamp Society and the Benjamin Rush Society.

"Of all the Rush people I have known, Ruth Schmidt most completely represented the very essence of this institution," says Leo M. Henikoff, MD, president and CEO. "At the time of her death, she had given 67 years of her life to Rush, and although she 'retired' in 1974, she never retired from the institution and its people."

"Everyone wanted to know Ruth," says Karen Van Dyke Lamb, ND, RN, president of the Nurses Alumni Association. "She was an outgoing person who got energy from being around people, and she wanted to see the best in people."

Dedicated to education, she established the Ruth E. Schmidt Endowment Fund for Nursing Education and the James G. Clark, MD-Ruth E. Schmidt, RN, Endowment Fund for Medical Education to provide financial assistance to students in need. Gifts in her memory may be made to these funds.

She is survived by a sister, Carolyn, who lives in Duluth, Minn.

For information on making a gift in Miss Schmidt's memory, please contact the Office of Philanthropy at (312) 942-2569.

## RUSH UNIVERSITY AWARDS MORE THAN 300 HEALTH DEGREES

The 25th annual Rush University commencement took place on June 14 at the University of Illinois at Chicago Pavilion. This year's ceremony was the first ever at the UIC Pavilion, and more than 2,800 guests and Rush faculty members attended.

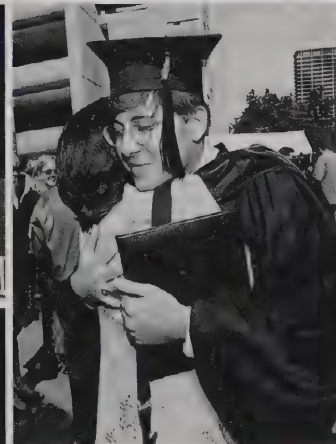
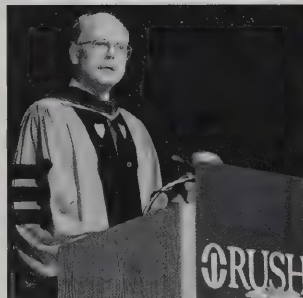
Gail Wilensky, PhD — the John M. Olin senior fellow at Project HOPE, an international health education foundation — gave the commencement address and was awarded an honorary degree from Rush.

In her address, Wilensky discussed the challenges and opportunities that face patients and providers in today's managed care environment. Though Wilensky is concerned about some of the changes in health care, she predicts that many of the kinks will be worked out of the new system.

"The most successful healthcare plans are the ones that are responding to concerns that have been raised by patients concerning choice of physicians and access to specialists," Wilensky said. "These plans are instituting open access to physicians outside their networks and direct access to specialists."

The plans are also relying on the use of clinical pathways, capitation of specialists and better use of the continuum of healthcare professionals, she said.

In all, Rush University awarded 315 degrees, including 109 in the College of Medicine, 162 in the College of Nursing, 38 in the College of Health Sciences and six in the Graduate College. Rush has conferred nearly 7,500 degrees since the university was established in 1972.



Photos: Bruce Powell



## FIVE TRUSTEES NAMED TO BOARD

Robert H. Cohn; Barbara Fuller, MD; Harold S. Jensen; Harold Kessler, MD; and Pamela B. Strobel have been named to the Board of Trustees of Rush-Presbyterian-St. Luke's Medical Center.

Cohn is the former chairman and chief executive officer of CFS Continental, Inc., a food service company. Fuller, a medical oncologist, is the new president of the Alumni Association of Rush Medical College and is an associate attending physician at Ingalls Memorial Hospital in Harvey, Ill., and Physician's Community Hospital in Munster, Ind.

Jensen is the retired chairman of Metropolitan Structures, an international real estate development firm. Kessler is past president of the Alumni Association of Rush Medical College and is the director of the HIV Treatment Program and associate director of infectious disease at Rush. Strobel is the vice president and general counsel for Commonwealth Edison Company.

## GLANT AND GOLDBERG NAMED TO ENDOWED CHAIRS

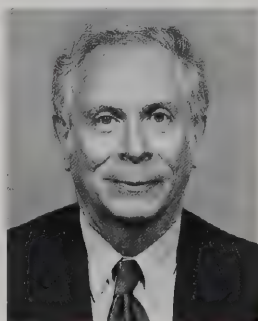
The Board of Trustees recently made two appointments to endowed chairs at Rush University. Tibor T. Glant, MD, PhD, was named to the Jorge O. Galante, MD, Chair of Orthopedic Surgery, and Arnold I. Goldberg, MD, was named to the Cynthia Oudejans Harris, MD, Chair of Psychiatry.



Tibor T. Glant, MD, PhD

*Tissue Research and the Journal of Bone and Joint Surgery.*

Goldberg is a professor and senior attending physician in the Department of Psychiatry. He is widely published and a past president of the Chicago Psychoanalytic Society. Goldberg also serves on the faculty of the Institute for Psychoanalysis of Chicago, where he was director for four years. A gifted teacher, Goldberg has received the Benjamin Rush Award for Best Teacher in Psychiatry six times during his tenure at Rush.



Arnold I. Goldberg, MD

Glant, who joined the Rush faculty in 1988, is a professor of biochemistry, internal medicine and orthopedic surgery. An internationally recognized biochemist, Glant's research focuses on how cartilage is destroyed in arthritis and how bone loss occurs following artificial hip implant surgery. He is a member of the National Institutes of Health General Medicine Study Section and a consulting reviewer for several medical journals, including the *Archives of Biochemistry, Connective*

## RECENT APPOINTMENTS AT RUSH

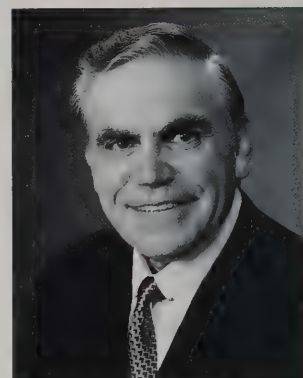
Joseph J. Amato, MD; Hans G. Klingemann, MD, PhD; and Dale R. Sumner Jr., PhD, were recently appointed to new positions at the Medical Center.

Joseph J. Amato, MD, was named director of the Section of Thoracic Organ Transplantation. He joined Rush in 1995 as professor of surgery, professor of pediatrics and director of the Section of Pediatric

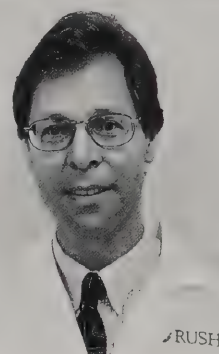
Cardiothoracic Surgery. In this new position, Amato will have clinical, research and administrative responsibility for the heart, lung and heart-lung transplantation programs for adults and children.

Hans G. Klingemann, MD, PhD, was named director of the Thomas Hazen Thorne Bone Marrow Transplant Center of the Rush Cancer Institute. Before coming to Rush, he was an attending physician at both Vancouver Hospital and Health Sciences Center and the British Columbia Cancer Agency, as well as professor of medicine at the University of British Columbia. He will supervise both pediatric and adult bone marrow transplant programs.

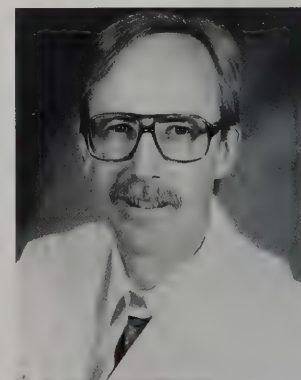
In September, Dale R. Sumner Jr., PhD, was named chairman of the Department of Anatomy. He is a professor and senior scientist with joint appointments in orthopedics and anatomy. Sumner came to Rush in 1984 for postdoctoral training in orthopedic research. His research focuses on bone loss in patients with total hip replacement and fixation methods for knee implants.



Joseph J. Amato, MD



Hans G. Klingemann, MD, PhD



Dale R. Sumner Jr., PhD



## HOW NORWAY'S PHYSICIANS DEFIED THE NAZIS

Asbjørn Sunde was on the run from the Nazis. Sunde was wanted for killing an officer in the Norwegian National Police who was cooperating with the Nazis. If caught, Sunde would face imprisonment, torture and execution. Sunde's capture would be devastating for the Norwegian resistance movement since he knew the names and activities of many Norwegians who worked underground to resist German occupation.

To help Sunde evade the Nazis, Ole Jacob Malm, MD, a key player in the resistance, enlisted the help of another physician to alter Sunde's appearance. The physician injected a paraffin compound under the skin of Sunde's face to eliminate a cleft chin and fill out the tissue around his nose and eyes. With a new face, Sunde eluded his pursuers and remained in Norway, undetected, throughout the war.

Decades later, Malm shared his story with Maynard Cohen, MD, PhD, professor and chairman emeritus in Rush's Department of Neurological Sciences. It is one of the many stories of Norwegian physicians' underground activities during World War II that Cohen compiled in his book, *A Stand Against Tyranny*, published earlier this year by Wayne State University Press.

Norway's government hoped that a position of neutrality would keep them out of the war. But they were blind to Norway's geographical significance: Free passage through the North Sea, just south of Norway, was of vital strategic importance to Germany. In spring 1940, the Nazis swiftly took control of the country. Norway's small, poorly trained and ill-equipped army had little chance against the well-trained, heavily armed invaders. With the help of a few Norwegian traitors, the Nazis occupied the country until the end of the war.

"The bitterness of five oppressive years of Nazi occupation still hung heavily over Oslo when I first arrived in Norway," writes Cohen in the preface to his book. Cohen was in medical school in the United States during World War II and unaware of Norway's struggles. But in 1951, his education about Norway's role in the war began. At that time, he was invited to Norway to teach neuropathology to University of Oslo residents and medical students.

A few days after he arrived, he got his first inkling of the underground activities of Norway's physicians. A Norwegian colleague remarked that the attic above the lab where they worked housed an illegal radio receiver used during Nazi occupation. Such tidbits piqued Cohen's curiosity and spurred his decades-long research project.

Cohen began his book in part to test a theory: "I had come to the conclusion ... that the doctors' roles in the resistance were very significant," he said. After studying old newspapers and interviewing about 20 physicians who were active with the resistance, he proved his theory true.

As his book details, Norway's physicians used their medical expertise and their privileged place in society to carry out various acts of resistance, such as passing along information about who was being targeted by the Nazis for execution and caring for wounded Norwegians on the run. "In the guise of the practice of medicine, [physicians] could contact virtually any of their countrymen without arousing Nazi suspicion. Physicians maintained their automobiles, enjoying a freedom of travel denied to others, and could bypass curfews with impunity," Cohen writes.

— Tracy Binius

## UNCOVERING THE ROLE OF NORWEGIAN PHYSICIANS DURING WWII



Maynard Cohen, MD, PhD, interviewed physicians active in Norway's resistance movement for his book, *A Stand Against Tyranny*.



Ole Jacob Malm, MD, organized and directed the communications network for Norway's resistance movement.



Jan Jansen, MD, editor and publisher of Norway's leading "illegal" newspaper during the war.



Kristian Kristiansen, MD, who equipped 100 secret field hospitals for use in expected Allied invasions of Norway.

A copy of Cohen's book can be ordered through your local bookstore or by calling Wayne State University Press at (800)-978-7323.



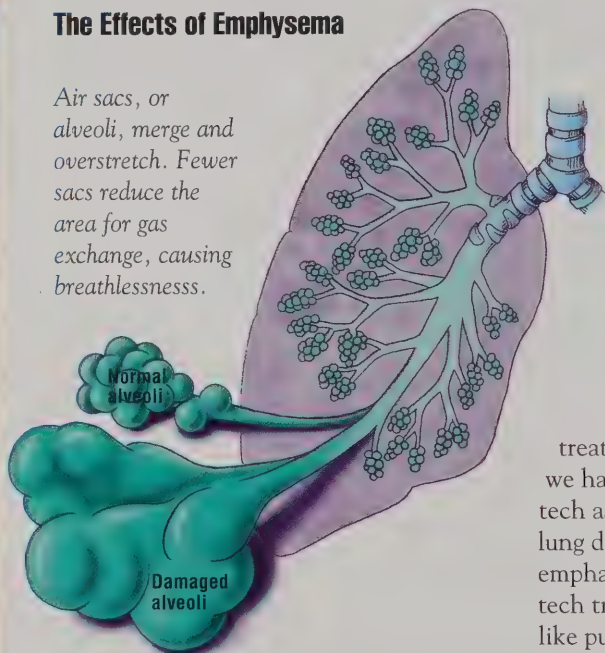
## LUNG TRANSPLANT GIVES EMPHYSEMA PATIENT A SECOND WIND

Most people view grocery shopping as a chore. Not Sonia Livsey. For Livsey, a trip to the neighborhood food store is an adventure — the kind of spontaneous outing that, just six months ago, she was unable to enjoy.

For three years, Livsey had suffered from advanced pulmonary emphysema, a

### The Effects of Emphysema

Air sacs, or alveoli, merge and overstretch. Fewer sacs reduce the area for gas exchange, causing breathlessness.



Illustration, Kristen Wienandt

lung disease that made even simple activities, like walking up a flight of stairs, a struggle. She required oxygen therapy day and night. Faced with these obstacles, Livsey had gradually become a prisoner in her home, unable to run even routine errands without a great deal of planning and assistance.

But thanks to a lung transplant at Rush on May 27, the 63-year-old Montgomery, Illinois, woman has steadily regained her vitality and independence. By early June, she no longer required oxygen therapy. Within two months, she was again enjoying the simple pleasures — like taking an evening stroll — that most of us take for granted. "Sonia is doing things she hasn't done for years, which is wonderful for her — and wonderful for us to see," says Steven Kesten, MD, medical director of the Advanced

Lung Disease and Lung Transplant Program at Rush.

Even grocery shopping is an exciting experience, says Livsey, who, this past July, visited her neighborhood Eagle food store for the first time in three years. "There were all of these new brands of food I had never seen," she says. "It was kind of a thrill."

Livsey's transplant was performed by Michael Bresticker, MD, surgical director of Rush's Advanced Lung Disease and Lung Transplant Program. Through the program, Kesten and Bresticker lead a multidisciplinary staff of specialists — physicians, nurses, dietitians and physical therapists — who treat adults and children with all forms of severe lung disease.

Rush offers a continuum of treatments, says Kesten. "On one side, we have transplant, which is as high-tech as you can get in treating advanced lung disease," says Kesten. "But we also emphasize low-tech treatments like pulmonary rehabilitation, which involves education, exercise and nutrition. We find that, for some patients, a combination of high-tech and low-tech approaches works very well."

Sonia Livsey was the first person to undergo a transplant through the Rush program. Since her surgery, six more lung transplants have been performed at Rush. Like Livsey, approximately

half of these patients underwent single-lung transplants, in which the more diseased lung is removed and replaced with a healthy organ. "For the majority of patients, single-lung transplants offer significant benefits," says Bresticker. Double-lung transplants and heart-lung transplants — which are more complicated surgeries — are usually reserved for younger patients with progressive conditions, such as cystic fibrosis and pulmonary hypertension.

For people suffering from all forms of advanced lung disease, a lung transplant can be a last chance for life. Thanks to advances in treatment before and after transplant, such patients also face steadily improving odds for long-term health. "People who undergo lung transplants today face better prognoses than ever before," says Bresticker.

Last year, more than 800 lung transplants were performed nationwide, mainly for people with advanced pulmonary emphysema — a disease that responds well to transplant. But for every patient who receives a new lung, several



Lung transplant patient Sonia Livsey and her husband, Arthur, at the grocery store.

Photo: Andrew Campbell



continue to wait for suitable donors to be found. And many don't survive the wait.

This shortage is compounded by the fact that, even when a suitable donor is found, the lungs are often damaged and unusable. "Lungs are extremely fragile — far more so than hearts, livers and kidneys," explains Bresticker. "In many cases, donors' lungs are injured by whatever trauma causes their deaths, or during attempts to resuscitate them."

When a donor's lungs are suitable

for transplant, formidable logistical challenges remain. "Speed is essential in getting the lungs to the recipient," says Bresticker. "Ideally, a lung should be transplanted within four hours of its removal from a donor's body. This limits centers geographically in terms of where they can search for potential donors."

Sonia Livsey, who waited 10 months for a donor to be found, considers herself lucky. She credits her Rush physicians and nurses with restoring her physical

health — and her family with bolstering her emotionally.

In July, Livsey enjoyed a visit from the newest member of her family — 2-month-old Jordan, her first great-grandchild. For Livsey, the visit was another reason to cherish her newfound health. "It's been a rough six weeks, but I know I made the right choice in having the transplant," she says. "I feel like I've been set free. I can once again enjoy my life, doing the things I like to do."

— Cheryl Janusz

## ADVANCE MADE IN THE FIGHT AGAINST HUNTINGTON'S DISEASE

Researchers at the Rush Neuroscience Institute have developed a potential breakthrough treatment that may help the thousands of Americans who suffer from Huntington's disease. Preliminary studies by scientist Jeffrey Kordower, PhD, and his team suggest that a small capsule, surgically implanted in the brain, will slow the relentless brain-cell death involved in this deadly neurological illness.

No treatment or cure is now available for Huntington's disease, a hereditary disease that affects an estimated 30,000 Americans. Symptoms include loss of memory and concentration, personality changes and disabling motor difficulties such as twitching and clumsiness. The disease grows steadily worse over time, ultimately causing death within 10 to 15 years.

The promising new treatment is based on research that Kordower and his associates conducted on monkeys. After injecting the animals with a toxin that caused them to develop Huntington-like symptoms, the scientists surgically implanted capsules in the animals' brains. Over time, these capsules released genetically altered cells containing celica neurotrophic factor, a substance that protects brain cells. This drug-delivery system sharply reduced the damage caused by the poison.

A trial on Huntington patients will be conducted in Europe to test the safety and effectiveness of the approach on humans, says Kordower. If this and other trials prove successful, this innovative treatment could offer hope for people with this disabling disease. "Huntington's usually starts in a person's 30s, 40s or 50s," says Kordower. "People who have a genetic predisposition could be carefully monitored. Once symptoms appeared, they could have this capsule implanted, which would hopefully slow the degenerative process."

While the gene defect that leads to Huntington's can be detected before birth, most people don't find out they're at risk until their mother or father develops the disease, says Kordower. A person has a 50 percent chance of developing



Rush scientist Jeffrey Kordower, PhD, is conducting research that may lead to a treatment for Huntington's disease.

Huntington's if a parent has the disease.

"People have often avoided being tested for the disease because there is no cure," Kordower says. "But if treatment became available, we would probably see an increase in testing."

Kordower emphasizes that it could be 10 years or more before this treatment is widely available. But he is hopeful that the treatment will prove successful. He points to trials of similar treatments for people with chronic pain and other problems. For instance, cancer patients have had capsules implanted in their brains that release opiates, successfully relieving the disabling pain of cancer.



## HIGH-DOSE TREATMENTS THREATEN CYSTIC FIBROSIS PATIENTS

Children with cystic fibrosis have been threatened by a new disease caused, ironically, by some of the treatments they are given for this devastating disorder.

John D. Lloyd-Still, MD, head of the Cystic Fibrosis Center at the Rush Children's Hospital, is on a campaign to warn physicians of the dangers of administering high doses of pancreatic enzymes for cystic fibrosis patients, and is conducting research that has implications for other high-dose treatments.

"There's been an epidemic of a new disease that causes the colons of patients with cystic fibrosis to become thickened and obstructed as a result of treatment with pancreatic enzymes," Lloyd-Still says. The obstruction makes it necessary for many patients to have their colons removed. In some instances, the disease has been fatal.

In most patients with cystic fibrosis, the pancreas doesn't function properly.

These patients must receive treatment with enzymes that increase their ability to absorb fats.

In the early 1990s, physicians began using cystic fibrosis medications high in lipase, an enzyme naturally produced by the pancreas to help the body digest fat. A few years later, physicians started seeing colonic strictures in children with cystic fibrosis.

After the first report of the epidemic was published, the FDA responded by banning high-dose enzyme products containing more than 20,000 units of lipase.

With Robert E. Kimura, MD, head of neonatology at Rush, Lloyd-Still is conducting research — using an animal model — into the pathophysiological mechanisms of this new iatrogenic disease.

The Rush research may have implications for other high-dose treatments being prescribed for cystic fibrosis patients. Preliminary results suggest that high doses

of anti-inflammatory drugs like ibuprofen may also induce intestinal and liver disease.

— Dennis Connaughton



Photo: Jean Clough

Cystic fibrosis patient John Weyland (right) puts a vest on his friend Ben Pacey that helps alleviate breathing problems.

## RESEARCHERS LOOK FOR GENETIC CLUES THAT PRECEDE BREAST CANCER

By comparing healthy and cancerous tissue in breast cancer patients, Rush researchers hope to detect how normal breast cells turn deadly.

"We hope to identify the changes cells make on their path from healthy to malignant," says medical oncologist Melody Cobleigh, MD, director of the

research project. Cobleigh also heads the Rush Comprehensive Breast Center.

Findings from this research could help doctors assess a patient's risk and possibly predict the development of breast cancer years in advance.

Cobleigh and her colleagues began the preliminary work on the project more than three years ago, and they started enrolling patients in January 1996. To date, the researchers have signed up 32 patients with early-stage breast cancer.

As part of the study, the patients have agreed to undergo a gene screening. This involves having needle biopsies of four specific sites — one cancerous, three noncancerous — in their breasts before the cancerous tissue is surgically removed. The investigators will examine five specific genes within breast tissue cells from each biopsy site and track any abnormalities in the genes that may precede cancer.

Co-investigators for the project include Paolo Gattuso, MD; Nancy Wood, PhD; Denise Oleske, PhD and Thomas Witt, MD.

With the findings from this research, doctors hope to be able to identify women at risk for breast cancer who might benefit from preventive drug therapy. In separate research, Cobleigh has studied drugs such as tamoxifen and fenretinide, a vitamin A derivative, in an effort to prevent and treat breast cancer. One pilot study involved giving women with metastatic breast cancer — cancer that has spread to other parts of the body — either standard doses of tamoxifen or tamoxifen and fenretinide. Cobleigh found that tamoxifen along with large doses of fenretinide seems to shrink established cancer. This study paved the way for a national clinical trial, which she heads, that involves 1,500 women with early-stage breast cancer.

— Laura Ramos



Photo: Jean Clough

Medical oncologist Melody Cobleigh, MD



## PERISHED MEMORIES: RESEARCHERS TRY TO UNLOCK THE MIND'S MYSTERIES

As a promising math and science student in high school, Amy Lenik had a head for figures and wanted to become a biochemist. But today, the former National Honor Society member is stumped by the question, "How old are you?"

That's because 26-year-old Lenik has permanent anterograde amnesia, which means she is unable to form new memories, although she can remember her childhood in detail. In a matter of minutes, she'll forget where she is or who is talking to her. But she remembers what her middle school looked like and where her locker was.

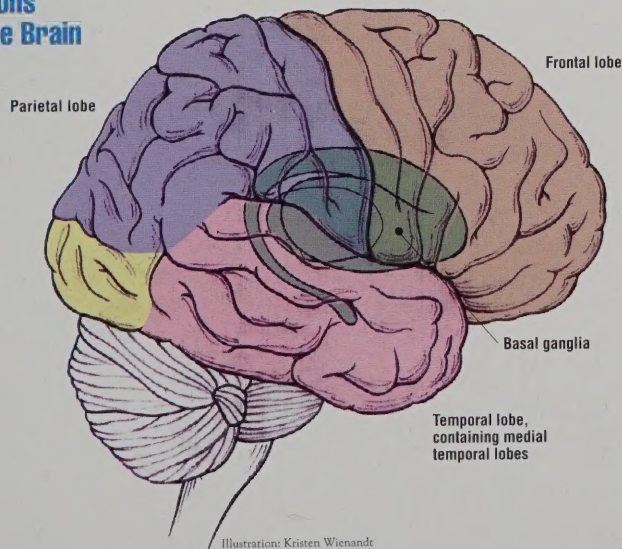
Lenik is one of several amnesics taking part in a study on memory loss. With funding from the National Institute of Mental Health and the National Institute on Aging, a team of researchers from Rush and elsewhere is studying people with Alzheimer's disease and other memory disorders.

Using advanced brain-imaging techniques, the researchers are investigating the physical changes that occur in the brain when someone develops serious memory loss, making it easier to determine whether someone has Alzheimer's versus amnesia. Today, people with serious memory problems are subjected to a battery of behavioral tests to determine a diagnosis.

"This research may help us diagnose memory loss in a whole new way," says Glenn Stebbins, PhD, a clinical neuropsychologist at Rush who leads the research team. "The research will show us the anatomical, rather than just the behavioral, changes associated with different kinds of memory loss," says Stebbins.

At 17, Lenik suffered a severe epileptic seizure that permanently damaged her temporal lobes, the large regions at the sides of the brain involved in memory processing. Lenik has to rely on her mother, Joanne, to be her external memory and date book, reminding her what she needs to do each day and who people are.

### Regions of the Brain



*Amnesic Amy Lenik tackles a computer game with her mother, Joanne.*

Curiously, Lenik is able to learn new skills: Each day, she remembers how to play computer games and surf the Internet — but she cannot remember how or when she learned to do this. The fact that anterograde amnesics like Lenik can learn and retain new skills has led the world's brain researchers to believe that several regions of the brain control memory. Researchers had long thought that the temporal lobes were responsible for storing memory, but now they think the process is more complex.

Using functional magnetic resonance imaging — a non-invasive, computer-imaging technique that "films" the brain as it is working — Rush researchers have been studying patients' brain activity for the last three years. The researchers ask participants like Lenik to perform various memory tests, like asking them to recall a string of words. Then, the researchers take a picture of participants' brains, using the fMRI, as they recall these words.

From this, the Rush team has found evidence that various regions of the brain control different types of memories (see illustration). "With each day, we learn more about how memory operates, and soon we may have a better way to diagnose memory loss," says Stebbins.

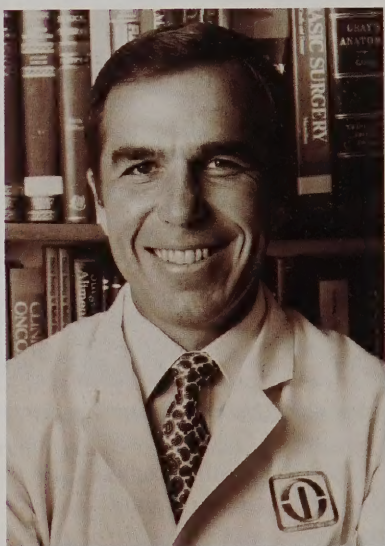
— Laura Ramos

Researchers believe that the medial temporal lobes and the frontal and parietal lobes of our brains store the "whats" of things — like remembering that a bike has two wheels. The frontal lobe, parietal lobe and the basal ganglia of our brains help us remember how to perform various skills, like how to ride a bike.



# IN MEMORIAM

## ROGER C. BONE, MD, 1941-1997

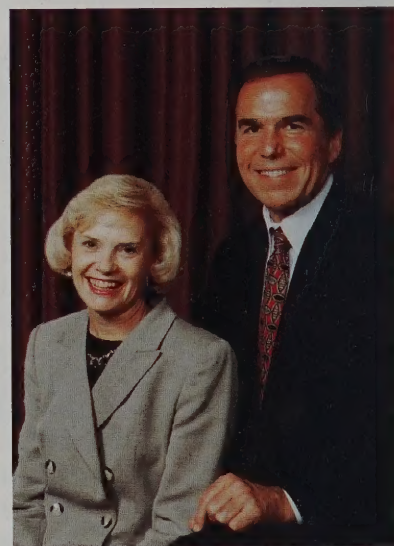


Roger C. Bone, MD

"THE DAY MY METASTASIS WAS CONFIRMED WAS, OF COURSE, VERY TRAUMATIC. THE INITIAL SHOCK CREATED ANXIETY AND CAUSED A FLURRY OF ACTIVITY AMONG MY BUSINESS ASSOCIATES AND OFFICE EMPLOYEES. WHAT SHOULD THEY DO? WHAT NEEDED TO BE DONE AND WHEN? FINALLY, I POLITELY CALLED A HALT TO ALL ACTIVITY FOR THE DAY. I TOLD THEM I WANTED TO GO HOME SO I COULD SIMPLY SIT AND LOOK AT THE RIVER AND SPEND TIME WITH MY FAMILY.

WHICH IS WHAT I DID."

Roger C. Bone, MD  
from *Reflections. A Guide to  
End of Life Issues for You and Your Family*



Roger C. Bone, MD, and his wife, Rosemary.

Roger C. Bone, MD, distinguished professor of medicine at Rush-Presbyterian-St. Luke's Medical Center and former dean of the Rush Medical College, died June 8 at Rush. He was 56.

Dr. Bone had battled kidney cancer since 1993. He shared his innermost feelings about the dying process and how to deal with it in major publications, including the *Journal of the American Medical Association*.

Michael Davidson, MD, president of the Chicago Center for Clinical Research, said, "When Roger Bone got cancer, it became a learning experience for him. Other people learned from his insight and courage about what all of us have to go through — dying."

A pulmonologist and critical care specialist, Dr. Bone joined the Rush medical staff in 1984 as chairman of the Department of Internal Medicine. He also served as vice president for medical affairs and chief of the sections of pulmonary and critical care medicine.

A graduate of Hendrix College in Conway, Ark., Dr. Bone earned his MD degree from the University of Arkansas Medical School. He completed his residency

training and was a pulmonary fellow at the University of Texas Southwestern Medical School.

Dr. Bone served in Vietnam as an army captain in the medical corps, receiving a Medal of Valor in 1969. He was actively involved in research throughout his medical career, and he received many honors and awards for his efforts. In 1995, he was named a master fellow of the American College of Chest Physicians, becoming only the sixth physician in the organization's 61-year history to receive the honor. He was also a master fellow of the American College of Physicians.

The recipient of 57 research grants, Dr. Bone was author of more than 1,000 articles and editor of 56 books.

Dr. Bone was also a past president of the American College of Chest Physicians and the International Academy of Chest Physicians and Surgeons. In 1994, he received the American Cancer Society Courage Award.

Born in Bald Knob, Ark., in 1941, Dr. Bone is survived by his wife, Rosemary, and his two daughters, Mary Katherine Krause and Cynthia Larson. ■









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